Buckinghamshire Healthcare NHS
NHS Trust

Buckinghamshire Healthcare NHS Trust

Annual report 2013 / 14

Safe & compassionate care, every time

Contents

1. Our Trust

Buckinghamshire Healthcare NHS Trust is a major provider of integrated hospital and community services for people living in Buckinghamshire and surrounding counties, providing care to over half a million patients every year. In addition we provide specialist spinal services at our world renowned National Spinal Injuries Centre for patients across England and internationally.

Our aim is to provide safe and compassionate care, every time to our patients. Our highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support staff deliver this care.

Buckinghamshire Healthcare NHS Trust is one of the first integrated acute and community providers in the country, and is the major provider of specialist, acute and community healthcare services for the people of Buckinghamshire. We deliver our services from a network of facilities including:

- A range of community settings - health centres, schools and patients' own homes;
- Five community hospitals;
- Two acute hospitals located in the two most densely populated areas of Buckinghamshire - High Wycombe and Stoke Mandeville, Aylesbury.

Over 5,700 members of staff provide integrated services to approximately half a million people, including the dispersed population of Buckinghamshire and the surrounding areas of Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire). As well as being a major provider of community and acute hospital care, we are well known for our specialist services. The internationally renowned National Spinal Injuries Centre is one of only a few such centres of expertise in the UK. We are recognised nationally for our urology and skin cancer services. Similarly at a regional level we are a specialist centre for burns care, plastic surgery and dermatology.

2013/14 in numbers:

- 598,634 patient contacts in the community
- 179,053 new outpatient attendances at our hospitals
- 304,701 follow-up outpatient attendances
- 5,915 elective inpatient admissions
- 39,685 elective day case admissions
- 28,225 emergency admissions
- 76,495 people attending our emergency services.

Where we are based

We provide inpatient facilities from two acute and five community hospitals in Buckinghamshire, and care in people's own homes and from over 20 other settings such as health and leisure centres and GP practices. Our community health services include adult community healthcare teams (district nursing, occupational therapy and physiotherapy), services for children and families, intermediate care, health visitors, community dental services and palliative care.

The acute hospitals

- Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Wycombe Hospital, Queen Alexandra Road, High Wycombe, HP11 2TT.

Our main community facilities

- Amersham Hospital, Whielden Street, Amersham HP7 0JD
- Buckingham Hospital, High Street, Buckingham MK18 1NU
- Chalfont & Gerrards Cross Hospital, Hampden Road, Chalfont St Peter SL9 9SX
- Marlow Hospital, Victoria Road, Marlow SL8 5SX
- Thame Community Hospital, East Street, Thame OX9 3JT
- Florence Nightingale Hospice, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Rayners Hedge Rehabilitation Unit, Croft Road, Aylesbury, Buckinghamshire HP21 7RD.

Our headquarters are at Amersham Hospital.

Visit our website for more details on our services www.buckshealthcare.nhs.uk

2. Chairman Foreword

I am delighted to join Buckinghamshire Healthcare NHS Trust at such an important time; when the Trust is working hard to address its challenges and implement improvements which will provide patients with *safe and compassionate care, every time*.

Significant improvements have already been made and I am proud to be working with Anne and the leadership team to deliver further quality improvements during 2014/15.

Our focus for the coming year will be on excelling in the delivery of clinical care, safety and patient experience; employing, engaging and developing high-calibre staff; ensuring all of our services are integrated and sustainable, and collaborating with our communities - from patients to partners - to ensure the best possible patient outcomes.

We will also be focussing on achieving our ambition to become a Foundation Trust. We will only proceed with this aim once we have achieved a rating of 'good' or 'outstanding' from the Care Quality Commission (CQC) but we will continue to prepare and develop ourselves for this as we believe that focussing on our ambition will help us all achieve the improvements we need to make in order to get us there.

At the time of writing we are still awaiting the outcome of our most recent CQC Chief Inspector of Hospitals' inspection. However, we have and continue to, implement our Quality Improvement Strategy and are continuously seeking patient, carer and service user feedback to help us refine and focus our improvements for maximum impact.

2014/15 brings with it the continued challenge of the major reform of the NHS brought about by The Health and Social Care Act 2012. Throughout 2013/14 we have built strong, collaborative working relationships with the Clinical Commissioning Groups and Specialised Commissioning Group and we will continue to develop these to ensure the best local NHS for the county.

I know some of the challenges facing us in the coming year are not simple but we are prepared, and committed, to meet them head on for the benefit of our patients, service users and staff.

Hattie Llewelyn-Davies
Chairman

3. Chief Executive's Foreword

Improving the quality of care we provide and the overall patient experience has been a real focus for us in 2013/14 and I believe we have taken great strides to achieve this during the last year against a backdrop of some significant challenges including the national Keogh Review and the *Speaking Out* investigation.

Our staff have shown great resilience in standing up to these challenges in order to improve patient experience and rebuild confidence in the services we provide and, I am pleased to say, we are starting to make an impact.

The national Keogh review in the summer of 2013 - triggered by higher than expected mortality rates but focussed on examining the overall quality of care provided across 14 hospital trusts - highlighted to us that we needed to focus our efforts on removing variability and ensuring greater consistency in our patients' experiences of our services. We took the findings of the review very seriously and I have been heartened to see the whole organisation pull together in order to make the necessary improvements. At a follow-up meeting in December 2013 the Keogh review team told us that we had made real progress against their recommendations, with all areas of concern being addressed. Our mortality rates were also reported in the 'as expected' range when the latest figures were released late in 2013.

At the beginning of 2013, we launched the *Speaking Out* investigation into the shocking and very serious historic allegations of abuse made against Jimmy Savile, looking at his activities at Stoke Mandeville Hospital. The investigation continued throughout the year and the Trust fully cooperated with this and other enquiries that have been ongoing. We also asked the local safeguarding board to look at our current safeguarding procedures to ensure nothing of this nature could happen again today; and we were reassured that they were approved as fit for purpose.

In January 2014 we launched our Quality Improvement Strategy, which provides us with a framework and focus to continue making improvements. We have three clear goals - to reduce mortality, reduce harm and ensure a great patient experience – and we have seen the development and implementation of improvement initiatives which I am delighted to say are making a difference to the lives of our patients on a daily basis and helping us in our journey to ensure that we deliver *safe and compassionate care, every time.*

Through our *Big Conversation,* which took place across the county, we have listened to and learned from patients and service users and have taken this feedback to develop and deliver service improvements which really make a difference. You can find out more about this on page 32.

I am pleased to report that 79% of patients say that the inpatient care they received from us was 'good' or 'excellent' and that 78% of patients reported that they were

'always' treated with dignity and respect[1]. This is testament to our committed staff but we will not rest on our laurels and intend to ensure even greater patient experience in the coming year by working on the areas where we scored less favourable, such as privacy in the A&E department.

Notably this year some of our key services have secured significant success. Wycombe Hospital's hyper-acute stroke unit has been ranked third in the country for its efficiency in treating stroke-related blood clots in a survey of stroke treatment centres by the Royal College of Physicians. This potentially life-saving and life-enhancing treatment is making a real difference for our stroke patients.

Similarly, the maternity unit at Stoke Mandeville Hospital was upgraded this year to level two of the national clinical risk management standards. These standards evaluate patient safety in maternity services across the country and, together with the recent refurbishment of the Rothschild Ward, ensure we are delivering a high-quality service for new and expectant mothers and babies.

This year we announced a £5 million investment in creating 150 additional nursing posts that will mean that we have more than the recommended number of nurses on our wards and enable senior staff to spend more time supporting and developing nursing practice. I am pleased to welcome all those who have joined us so far and look forward to working with them in the coming year. I am also delighted to welcome our new Chair, Hattie Llewelyn-Davies to the Trust. Hattie joined us in March and brings a wealth of knowledge and expertise from within the NHS and the public sector. Hattie's arrival brings a renewed energy to the Trust as we continue on our improvement journey. I am looking forward to working with her in 2014/15 and beyond in order to ensure that we are constantly improving the quality of our services and offering safe and compassionate care every time, for every patient.

My thanks go to outgoing Chair Fred Hucker who retired from the Trust in December. A stalwart supporter of the NHS; Fred devoted a lot of time and energy to the Trust for which we are thankful. His experience and knowledge of the region have been invaluable and he will be missed by us all. I am grateful also to Brenda Kersting, who stepped up as Acting Chair from December to March while we sought to appoint a new Chair. Brenda's leadership during this period was much appreciated by me and my colleagues.

Finally, I would like to say a huge thank you to all of our staff, volunteers, members and supporters who work tirelessly to provide high-quality healthcare across Buckinghamshire and beyond. I am immensely proud of everyone working for and with us and you will see why as you read through this report and read even more of our developments and achievements of the past year. There is of course more to do to continue improving quality across our services and I look forward to continue working together to make a real difference in 2014/15.

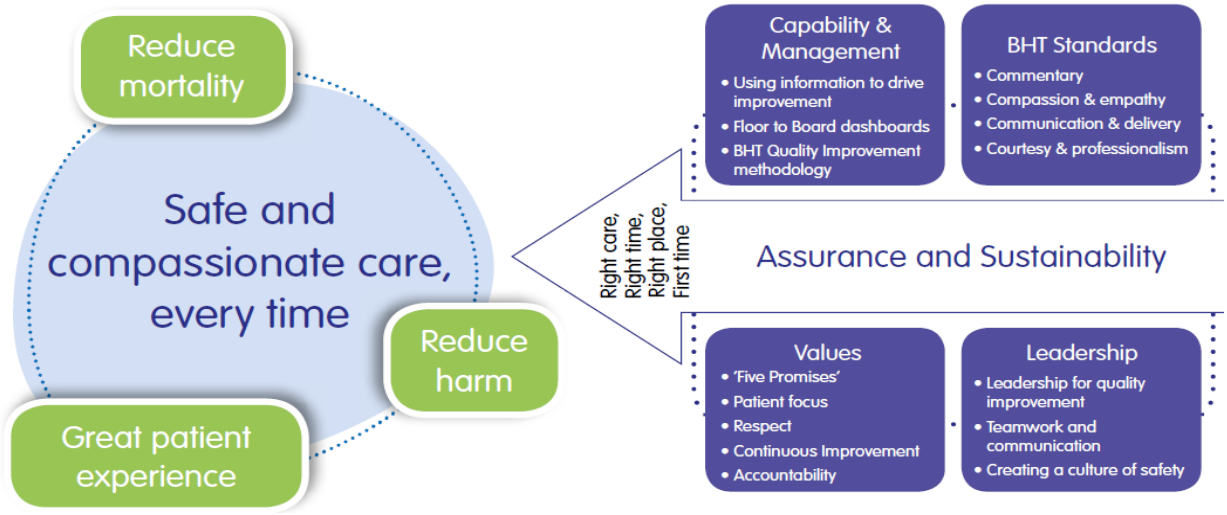
Anne Eden
Chief Executive

[1] Care Quality Commission national annual inpatient survey

4. Our mission and strategy

Our mission is "**Safe and Compassionate Care, Every Time".** To ensure constant focus and continual improvement towards delivering this mission it is underpinned by two core strategies, our Quality Improvement Strategy and our Clinical Strategy. These have been developed by the Board and senior leaders in the organisation, supported by staff sessions and workshops with patients and members to identify their aspirations for our services. Together these strategies provide a clear focus for Buckinghamshire Healthcare ensuring that we continue to develop and provide high quality, safe and sustainable services for the people of Buckinghamshire.

4.1. Our Quality Improvement Strategy



As illustrated above, our Quality Improvement Strategy clearly identifies the three key areas of focus for quality improvement within the Trust over the next two years. Each one of these has a specific and measurable outcome against which we can track progress. The strategic goals are outlined below.

1. **Reduce mortality**
2. **Reduce harm**
3. **Great patient experience**

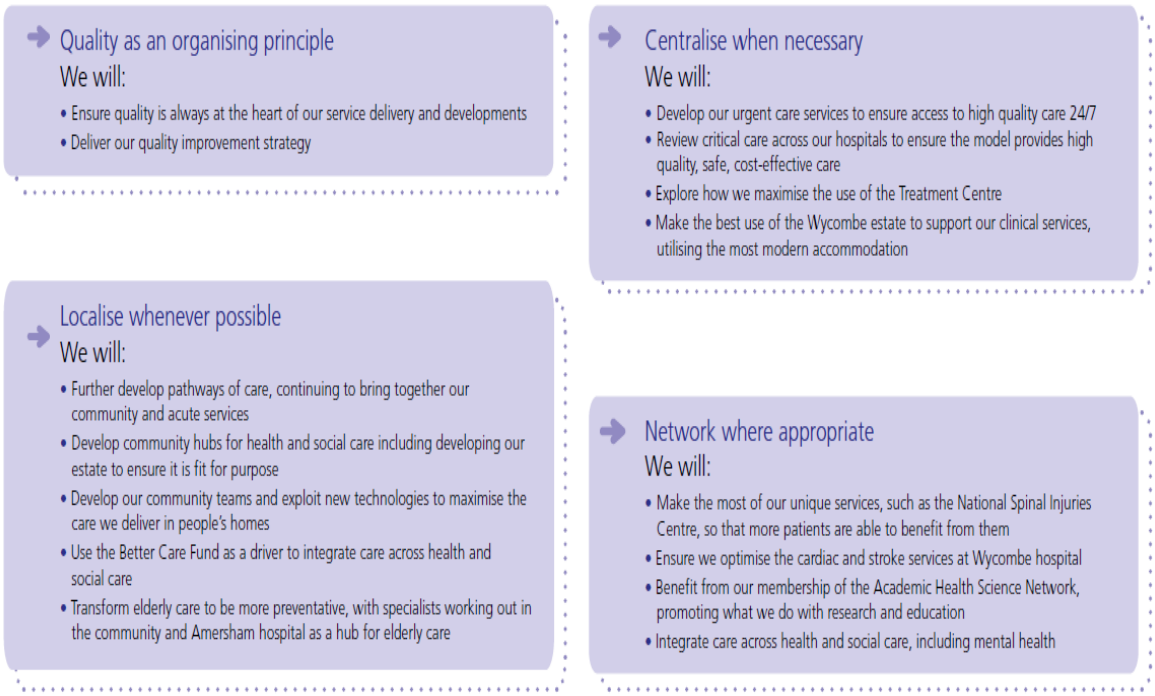
4.2. Our Clinical Strategy

Our clinical strategy has been developed alongside our Quality Improvement Strategy to ensure that Buckinghamshire Healthcare continually develops our clinical services not only to provide high quality care to our patients but to ensure the sustainability of our services into the future.

Our Clinical Strategy is aligned to four principles:

- Quality as an organising principle
- Localise whenever possible
- Centralise when necessary
- Network where appropriate

This is shown in more detail in the chart below:



4.3. Promises

Our promises were first developed in 2008 with patient and stakeholder involvement and they were then revisited in 2010 in recognition of our new integrated remit. The promises are reflected in our strategy, goals and objectives; continuing to guide all that we do today:

- **Clean and safe practice**, clinics and hospitals so you never need to worry unduly

- **A caring, helpful and respectful attitude** from approachable teams, who listen to you, involve you in decisions about your care and ensure you're clear about what to expect

- **Respect for your time** with care closer to home, offering choice and flexibility with a minimum of delays and cancellations. If you need to stay in one of our hospitals, we're making sure your stay is as short as possible, ensuring that you return home as quickly as possible

- **Easy access to comfortable and modern facilities**, offering privacy and dignity, personal space and good healthy food. We're committed to offering the best care in environments that promote health and wellbeing

- The **best clinical care** from teams of skilled healthcare professionals, who help you improve and maintain your health. Our commitment is to give you the highest standards of care.

4.4. A forward look to 2014/15

Our corporate objectives are the vehicle through which we ensure delivery of our mission statement and strategies. In January 2013 the Board and senior leaders within the Trust developed a set of long-term strategic objectives to take Buckinghamshire Healthcare to 2020. Our corporate objectives for the next two years, 2014/15 – 2015/16, are aligned to these longer-term strategic objectives.

They build on the past development of our clinical services and ensure quality and safety are at the heart of our service developments. They align to the health economy transformation programme shaping how we will work with our commissioners to ensure that each of our services is providing the best quality, safe and cost-effective care in a way that is sustainable into the future and that we are using technology and our estate to the best effect to achieve this.

The diagram below shows the connections between the mission, the strategy and the objectives:

Our objectives are provided in more detail below:

Corporate Objectives for 2014/15 and 2015/16
Quality - excel in the delivery of clinical care, safety and patient experience
Reduce mortality as reported by HSMR by 5 each year.
Reduce harm by ensuring at least 98% of all patient cared for by the Trust receive harm free care as measured by the safety thermometer
Offer a great patient experience as measured by having a net promoter score of 95 for Friends and Family Test in all areas
People - employ, engage, develop and retain the highest calibre dedicated people who are proud to work for Buckinghamshire Healthcare
Recruit an appropriately-skilled, permanent workforce
Ensure our workforce are well trained and developed to enable them to deliver safe and compassionate care every time
Ensure our staff are well led and actively engaged in building a strong and sustainable BHT
Optimised integration - ensure our full range of services, from community to highly specialised services, are integrated and sustainable
Transform our older people's pathway to be more preventative, involving and local
Develop our urgent care services to ensure access to high quality care 7 days a week 24 hours a day
Promote and develop mental health and learning disability services with a particular focus on dementia
External collaboration - work effectively across organisations and with our communities to ensure the best outcomes for patients and to influence the national agenda
Using the Better Care Fund as a driver work with partners to transform the interface between health and social care
Working with our partners in health and social care as well as the local populations, develop community hospitals as local hubs of care supported by proactive, effective and efficient Adult Community Health Teams
Work closely with social care, education and primary care to further develop our children's services
Efficiency - be a highly effective, sustainable Foundation Trust through maximising efficiency, productivity and cost effectiveness

Maximise our cost efficiency and effectiveness through delivery of our quality improvement strategy
Promote and develop our services, in particular our centres of excellence, based on robust service line management
Optimise the use of our estate and technological developments to facilitate high quality, responsive and cost effective service delivery

Managing risks in relation to our corporate strategy and objectives

The Board of Directors is responsible for reviewing the effectiveness of its internal control systems through its Board Assurance Framework (BAF). The document sets out the principal risks to achieving corporate objectives, along with assurances that effective controls have been put in place to protect patients, staff, the public, and other stakeholders against risks of all kinds. The Board Assurance Framework is reviewed by the Board at least three times each year.

5. Performance highlights and challenges

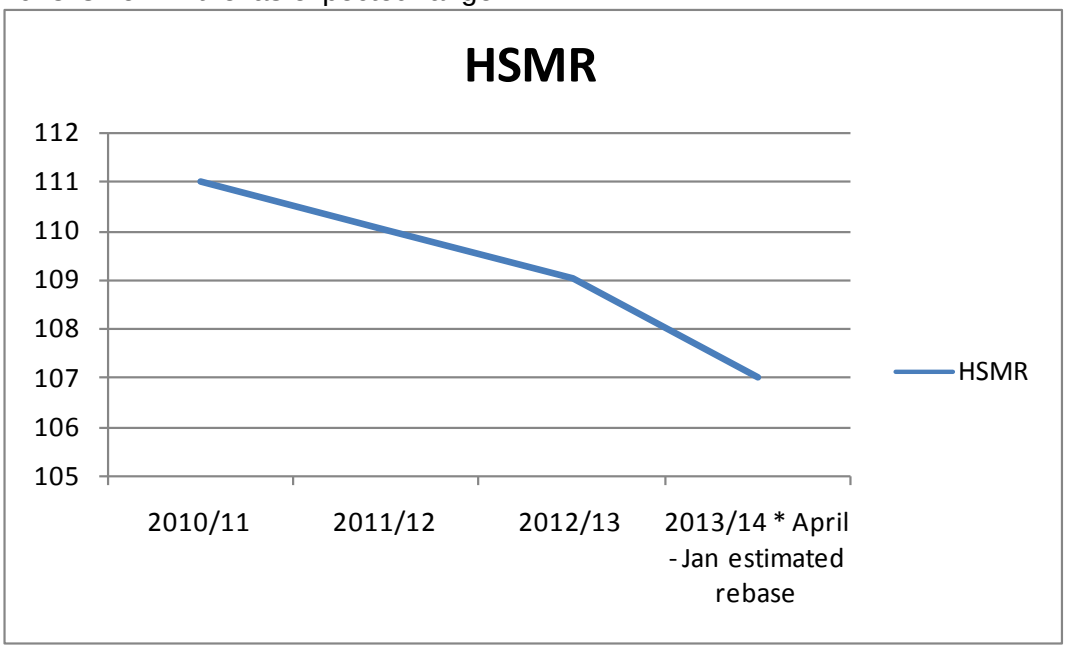
Safe and compassionate care, every time is our priority.

2013/14 saw further evidence of the benefits of being an integrated provider and this section sets out some of the highlights. .

5.1. Quality, safety and improving the patient experience

Mortality rate for Hospitals in Buckinghamshire improving

The Dr Foster Good Hospital Guide 2013, published in December 2013, showed that the mortality rate for hospitals in Buckinghamshire has continued to improve over the last year. The Hospital Standardised Mortality Rate for the year April 2012 – March 2013 is now in the 'as expected range'.



The weekend HSMR has continued to improve over the last two years with a significant reduction during since April 12.

The Guide looks at a number of different indicators to build up a picture of the quality and safety of a hospital's services. Buckinghamshire Healthcare NHS Trust has improved in a number of areas:

- The rate of people being urgently readmitted to hospital within 28 days of being discharged was in the 'as expected' range and below the national average.
- The rate of patients not receiving an operation for a fracture neck of femur (FNOF) within two days of admission was in the 'lower than expected' range and one of the best performers in the country. This means that the majority of patients are being operated on quickly within two days of admission and fewer patients having to wait more than two days.
- The number of emergency patients who needed and had an MRI scan on the day of admission was 'higher than expected' and one of the best in the country, showing that there is good access to MRI scans and unlike other hospitals in the country there was no difference between patients admitted during the week or the weekend.

Wycombe Hospital's HASU is third in country

Wycombe Hospital's stroke unit ranks third in the country for its efficiency in treating stroke-related blood clots, in a survey of stroke treatment centres from the Royal College of Physicians (RCP).

In the first of the college's new quarterly reports, for July-September2012/13, the hospital's hyper-acute stroke unit (HASU) comes third nationally London for thrombolysis, an injection that is used to disperse blood clots. Early administration of the treatment is important, as it can radically improve a patient's quality of life following a stroke. Wycombe's score, which takes into account five different factors around the speed and numbers of patients' thrombolysed, was 84.2.

The hospital was also the fastest outside London for accessing thrombolysis – the time from door to needle taking 38 minutes, against a national median of 59 minutes.

Buckinghamshire Healthcare's stroke service was in the top 10% of 151 trusts and best in the south central region with an 87 out of 100 score.

Maternity unit at Stoke Mandeville hospital awarded higher rating on patient safety standards

The maternity unit at Stoke Mandeville hospital has been awarded level 2 of the national clinical risk management standards that evaluate patient safety in maternity services across the country.

All NHS maternity services are assessed by the NHS Litigation Authority against the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards. The CNST Maternity Standards contain five broad standards (organisation, clinical care, high risk conditions, communication, postnatal & newborn care), comprising ten criteria within each.

Assessors visited the maternity unit at Stoke Mandeville in December, for a two-day inspection but at the end of day one they were confident that they had seen enough evidence of meeting the standards and announced our rating would be upgraded from level 1 to level 2. An action plan has been put in place to ensure that patient safety continues to be a high priority and the team continues to learn and improve even further.

Improvements were also made to the unit building to improve the patient experience. The Rothschild maternity ward at Stoke Mandeville Hospital has undergone an extensive refurbishment which was completed in 2014r. Each of the six bedded bays within the ward was upgraded with an en-suite bathroom and toilet, which also improved accessibility for wheelchair users**.** In addition, the existing bathroom, toilets and nurses' station were upgraded and new flooring has been laid throughout the ward.

Trust continuing to provide good patient experience

80 per cent of patients rated the inpatient care they received from Buckinghamshire Healthcare NHS Trust as 7 or more out of 10 where 10 is the best possible response, according to a recent national report.

The Care Quality Commission's (CQC) national annual inpatient survey looks at a wide range of areas, from arriving at hospital, to the quality of care received and discharge arrangements. Patients were asked about their experiences in July 2013.

In addition, 76 per cent of patients said they were 'always' treated with dignity and respect.

For most questions the Trust scored 'about the same' as other Trusts, and with little significant change from the 2012 national inpatient survey. However the responses indicate a significant improvement in the questions relating to members of staff telling patients about any danger signals they should watch for after they went home; and during the hospital stay being asked to give views on the quality of care. There was one significantly lower response to the question about confidence and trust in doctors treating you.

We are committed to improving the experience of our patients and this is a core component of our Quality Improvement Strategy and Quality Improvement Plan. In the light of changes since July 2013 we hope to see an improvement in our national inpatient survey results for July 2014.

The NHS Friends and Family Test (FFT)

In November 2013 results of the Friends and Family test show that between April and October 2013 4,245 patients in Buckinghamshire provided feedback on their experiences of local health services. Most inpatients continue to recommend the care they received from Buckinghamshire Healthcare NHS Trust.

The Friends and Family Test asks adult patients treated on hospital wards and people attending A&E whether they would recommend their care to friends and family based on their experiences. Patients are asked how likely they are to recommend the service to friends and family if they needed similar care or treatment.

We really value hearing back from patients about their experience in our hospitals. It helps us to understand what people think of our services and quickly identify where improvements need to be made. We also use it to share best practice between clinical areas when patients tell us about their good experiences.

Improving the patient experience is a priority area for the Trust. Whilst it is encouraging to see that our FFT scores are improving we are working hard to make sure our staff listen to patients and that we learn from what patients tell us about their care. We encourage patients to complete the Family and Friends Test.

One initiative that has resulted from patient feedback and is now improving the patient experience is a quick glance display to help patient and visitors identify staff on the ward.

As part of Buckinghamshire Healthcare NHS Trust's continuous improvement programme, the Trust held a series of 'Big Conversation' events to give patients and their families the opportunity to share their experiences face to face. The events provided an opportunity to listen and learn from those who use our services.

The events took place across the county between November 2013 and February 2014. More information about what we have done as a result of what patients and the public have told us can be found on our web-site at the following address: http://www.buckshealthcare.nhs.uk/abc/ .

Winter Paralympics

Stoke Mandeville hosted the first ever international leg of the Paralympic Torch Relay ahead of the eleventh Winter Paralympic Games held in Sochi, Russia. The historic Stoke Mandeville Flame Lighting Ceremony took place at Stoke Mandeville Stadium on 1 March 2014 and was accompanied by a programme of community activities including a gala celebration at the Aylesbury Waterside Theatre

The National Spinal Injuries Centre (NSIC) at Stoke Mandeville Hospital, birthplace of the Paralympics movement, was proud of its former patients who competed for Britain at the winter Paralympic games in Sochi.

The two former patients of the NSIC, who were both part of the British Disabled Ski Team, are Benjamin Sneesby from High Wycombe and Anna Turney from Northampton.

5.2. Service developments

New cardiac rehabilitation programme

The new Care4Today™ Heart Health Solutions cardiac rehabilitation programme at Wycombe Hospital was launched on 24 January 2014.

This pioneering new rehabilitation programme is delivered to cardiac patients across Buckinghamshire in the community from a newly refurbished unit at Wycombe

Hospital. The evidence-based programme aims to support patients to continue to live as full a life as possible, helping them to change their lifestyle and providing them with web-based tools to support them in managing their condition and help prevent a further admission to hospital.

The cardiac team at the Trust have been working in partnership with Janssen Healthcare Innovation to develop the Care4Today™ Heart Health Solutions pilot programme, complementing and enhancing the cardiac rehabilitation programme that the Trust already has in place.

This collaborative approach enables patients to have access to the latest digital technology. All patients have access to the programme as soon as they have suffered a cardiac episode. Patients then undergo a thorough heart health assessment in the new Cardiac Rehabilitation Unit with a specialist team who create individualised recovery programmes based on patients' own goals and requirements. As well as attending exercise classes and health reviews, patients and the health professionals looking after them are able to track progress online and patients also have access to a wide range of educational materials tailored to meet their specific needs, including a personalised website.

Over 250 patients have already taken part on the programme and have been extremely happy with the support and outcomes.

Investment in frontline nursing staff

We announced a £5 million investment to create an additional 150 nursing posts across the Trust in February 2014. Part of the investment will enable senior staff to spend more time supporting and developing nursing practice.

We want to deliver the best possible care for all our patients. This additional investment in our nursing workforce will mean that we have above the recommended number. Having more nurses on the ward will ease the pressure on our hardworking staff so that they can spend more time delivering the compassionate aspects of care.

This investment package will fund these additional posts on an ongoing basis, ensuring that the Trust relies less heavily on agency staff and more staff can be recruited on a permanent basis.

Care of older people in hospital wards

Following a Trust-wide review of patient care plans, measures have been put in place to ensure that information about patients' daily care needs, such as help with feeding, communication difficulties or those needing help going to the toilet, are recorded on patient handover notes. Individual patient care plans now include this information and handovers between nurses are audited monthly by the ward matron.

New patient safety boards had recently been put up in the entrances to wards across the Trust so that patients and relatives can see how well the ward is delivering care. The boards display information such as the number of hospital acquired infections, the number of falls and the number of complaints. Other improvements included the roll out of a named nurse for patients with complex multiple conditions so that patients have one named contact to get help and information about their care plan. New standardised uniforms had also been introduced across the Trust.

Dementia care

We have been working to improve dementia services for local patients. The following slides are excerpts from our dementia training for staff.

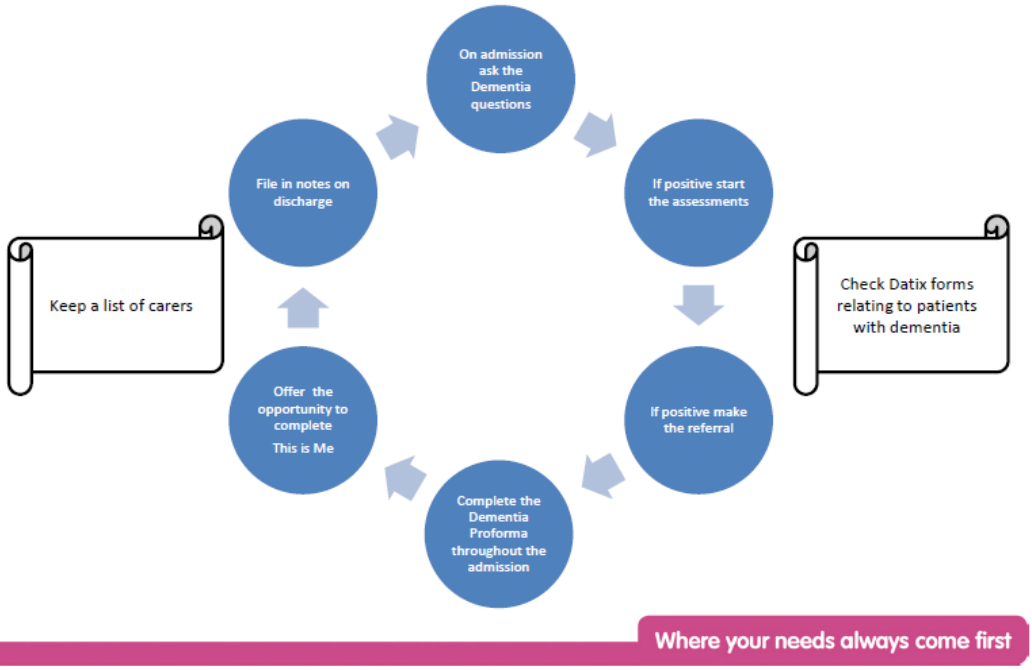
Buckinghamshire Healthcare NHS
NHS Trust

The Dementia Cquin 2013/14

Why your actions affect the targets

Where your needs always come first

What each ward needs to do



Dementia awareness training for healthcare professionals had been completed with on-going access for staff through online training tools. Local health organisations and charities are working together to ensure more people with dementia are being diagnosed and accessing treatment early. Four new memory assessment clinics in

GP surgeries are now take place in addition to existing clinics at Aylesbury, Amersham and High Wycombe.

The Trust has developed a draft Dementia Strategy and a Specialist Nurse for dementia will be starting in post in May 2014.

Breakthrough collaborative: recognition and management of the acutely unwell patient

The Breakthrough Learning Collaboratives bring together teams of healthcare professionals to focus on a particular area of patient care that has been identified as a concern. The teams work through how well we do things currently and what we could change to make a positive difference. We ask for a commitment from all the teams involved to test an agreed change back in their workplace using an iterative PDSA (plan-do-study-act) approach. Successful tests for change will be rolled out across the trust.

The collaborative methodology has had a great success rate in the USA and in other trusts in England, and enables large scale, fast pace change, built on the expertise of those working with patients every day.

In this exciting development an initial learning day was attended by 70 members of staff, and eight ward teams are now working on their 'tests of change' to improve the recognition and management of the acutely unwell patient.

Electronic Document and Records Management System

Evolve, is a new electronic document and records management system (EDRM) which has been rolled out since Autumn 2013. All specialties were covered by the end of March 2014. It will replace the Trust's paper-based patient records system so will require, over time, everyone who uses patient records as part of their job to work differently.

Evolve is a really important and positive development for us. It will protect the safety of our patients and improve their care by ensuring all patient records are accessible immediately by any clinician in the Trust. This makes decision-making and treatment faster and safer for our patients and avoids delayed discharge, additional tests or unnecessary appointments.

Better Healthcare in Buckinghamshire

We continue to implement and realise the benefits of Better Healthcare in Buckinghamshire. This includes:

- Continuing to work with GPs from Buckinghamshire Urgent Care (BUC) and ambulance service to develop the minor injuries and illness unit (MIIU) which opened in October 2012 at Wycombe. The service is run by GPs for patients with minor injuries and illness, who the GPs assess and then either treat, give advice about self-help or using a pharmacy, or refer onto the emergency service at Stoke Mandeville, or Wexham Park for those who live nearer. Strict clinical protocols have been developed between the Trust, GPs and ambulance service to govern the new network of minor injuries and illness, accident and emergency services across the county. They are aimed at giving patients the right treatment, in the right place, at the right time from the best-staffed and qualified teams.

- The centralisation of accident and emergency (A&E) services at Stoke Mandeville, a £5m expansion and modernisation programme is now complete.

- A specialist breast care centre at Wycombe Hospital, to provide initial assessment and first outpatient appointments for people with breast problems has been established. This exploits new digital technologies and include a faster 'one-stop-service' providing women with diagnostics and results on the same day.

- A multi-disciplinary day assessment unit (MuDAS) for older and frail people to allow them to be diagnosed and treated without an overnight admission, and a 'step-down' ward for elderly and medical patients, is now in place. Both at Wycombe Hospital.

5.3. Challenges facing the Trust

Sir Bruce Keogh's review into the quality of care and treatment provided by 14 hospital trusts in England

The outcome of the Sir Bruce review was published in July 2013. As a direct result of this 14 NHS hospital trusts were put under special measures for "fundamental breaches of care" by the health secretary Jeremy Hunt. Special measures are designed to produce results quickly, and typically a trust is expected to have made improvements within 12 months, at which point they will be inspected by the Chief Inspector of Hospitals.

We welcomed the report by Sir Bruce Keogh and although when the review teams spoke to patients may were 'unreservedly complimentary about the quality of nursing care they had experienced', the report highlighted a number of concerns.

A multi-agency risk summit was held in July where we worked with national experts and colleagues from other parts of the NHS and social care to put in place the next stage of our programme to improve the quality of care for our patients. ***Every Patient Counts*** was the Trust's commitment to improving the quality of care and treatment across our services to ensure we get it right for every patient, first time.

The Every Patient Counts action group was established to drive forward the action plan developed from the recommendations of the Keogh review.

The action plan had six main themes including:

- Strengthening our governance processes
- Building resilient urgent care pathways
- Developing a more open and transparent approach to gathering real-time feedback from patients
- Bringing together all improvement projects into a Trust-wide Patient Safety Strategy which includes looking at end of life pathways and continuing work to understand the causal factors associated with high HSMR in our integrated trust
- Working with colleagues across Buckinghamshire to ensure out-of-hours support is working well and effectively communicated
- Reviewing the recruitment, retention and engagement of staff.

Progress against delivery was reviewed by representatives from NHS England, Trust Development Authority, Care Quality Commission and local Clinical Commissioning

Groups in December 2013. The review acknowledged that we had made “real progress” in its efforts to improve the quality of care we provide. At the meeting our staff were able to detail a number of initiatives and developments that are now in place to help improve care and the patient experience.

These include:

- additional doctors working at the weekend in Stoke Mandeville Hospital, ensuring a daily review by a senior clinician of every emergency patient admitted over the weekend
- recruiting almost 70 nurses to fill vacancies on wards, with plans to recruit even more doctors and nurses over the coming weeks and months
- establishing a dedicated phone line for healthcare professionals in community services to access GP support more quickly out-of-hours
- opening a new Acute Medical Unit at Stoke Mandeville Hospital, seeing patients referred by their GP for urgent care or transferred from Wycombe Hospital. The unit enables these patients to bypass the A&E front-door, reducing their wait and improving their experience, as well as freeing-up capacity in the main A&E department
- installing new dashboards outside every ward so patients and visitors can easily see how well it is performing in key areas such as infection control, falls and the patient experience.

We have continued to implement our action plan. Finally, the Trust was subject to a re-inspection by the Chief Inspector of Hospitals’ team. The re-inspection took place between 18-21 March 2014. Initial feedback was generally positive, however the final report is awaited.

The new NHS

The Health and Social Care Act 2012 came into force on 1 April 2013. The Act brought about a major reform of the way the NHS operates. Changes included:

- Giving local authorities a much stronger role in shaping services. They have taken over responsibility for local population health improvement.
- Health and wellbeing boards bring together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and well-being.
- The majority of NHS care is now commissioned by Clinical Commissioning Groups (CCGs), which gives GPs and other clinicians responsibility for using resources to secure high-quality services. In Buckinghamshire there are two Clinical Commissioning Groups: Chiltern CCG and Aylesbury Vale CCG. Some services are commissioned Specialist Commissioning Groups (SCGs), in terms of Buckinghamshire we deal with the Wessex SCG
- CCGs and SCGs are supported by the NHS England, which allocates resources, and commission certain services, such as primary care. It also hosts clinical networks (to advise on single areas of care) and clinical senates (providing clinical advice on commissioning plans).

The Trust has been working collaboratively with our local CCGs and SCG to develop good working relationships and ensure the best local NHS for the population we serve.

A joint vision for integrated care in Buckinghamshire has been agreed. Regular meetings are held to discuss clinical and operational issues.

Speaking Out Investigation

The Speaking Out Investigation has been established to investigate the very serious allegations of criminality made against Jimmy Savile at Stoke Mandeville Hospital over many years. It is being led by an independent investigator and overseen by a Local Oversight Panel chaired by Trust non-executive director Keith Gilchrist.

This independent investigation has been undertaken alongside investigations by other NHS organisations and the Department of Health. The Speaking Out Investigation is being independently overseen by Kate Lampard, on behalf of the Department of Health, to ensure that it is robust and any lessons for the NHS can be quickly shared and acted upon.

The report of both the local and national investigations are expected to be published later in 2014.

Foundation Trust application

Our application to become an NHS foundation trust is currently on hold. We will not proceed further with our application until we achieve an overall rating of "Good" or "Outstanding" from the CQC in its new ratings system. We continue to work with the NHS Trust Development Authority to make sure we will be ready to proceed with our application..

5.4. Progress against national standards

The Trust has a robust performance monitoring framework in place, routinely measuring our business against a range of key performance indicators (KPIs). The framework allows the Board to monitor performance in key areas and supports our efforts to drive up quality, enhance patient experience, improve waiting times and deliver better, safer services.

KPIs are defined by the NHS Information Authority as the nationally recognised method for measuring performance in NHS acute trusts. In 2012/13 the KPIs covered commitments and standards set out by the Department of Health (DH) and Care Quality Commission in the operating framework.

Our performance in key areas is summarised in the table below.

2013/14 National Priority Indicators	**Performing**	**Q1 RAG Status**	**Q1 Actual**	**Q2 RAG Status**	**Q2 Actual**	**Q3 RAG Status**	**Q3 Actual**	**Q4 RAG Status**	**Q4 Actual**
Total time in A&E - 95% of patients should be seen within four hours	**>= 95%**	G	96.4% *	G	95.7% *	G	95.0%	R	92.6%

Delayed transfers of care	**<=3.5%**	G	1.8%	G	2.1%	G	1.8%	G	2.5%*
Mixed Sex Accommodation breaches	**0%**	G	0	G	0	G	0	G	0
VTE Risk Assessment	**>= 90%**	G	95.4%	G	94.2%	G	95.7%	G	97.0%
Hospital Acquired Infections									
MRSA Bacteraemia	**<=0 year**	G	0	G	0	R	2	G	0
Clostridium Difficile infection rate	**<=31 year**	R	12	G	8	R	8	R	7
Waiting times									
Admitted patients finishing their pathway – 90% within 18 weeks	**>= 90%**	G	91.8%	G	90.6%	R	87.6%	R	79.2%
Non admitted patients finishing their pathway - 95% within 18 weeks	**>= 95%**	G	97.8%	G	96.9%	A	94.6%	A	94.6%
Incomplete pathways - 92% within 18 weeks	**>= 92%**	G	92.2%	A	90.9%	R	81.3%	A	88.0%
Open pathways > 52 weeks	**0**	G	0	R	10	R	24	R	24
Diagnostic test waits <6 weeks	**< 1%**	G	0.7%	G	0.7%	G	0.3%	G	0.8%
Cancer Target									
2 week GP referral to 1st outpatient appointment	**93%**	G	99.3%	G	98.8%	G	99.3%	G	96.4% *
Max 2 week wait for all breast referrals	**93%**	G	97.5%	G	96.5%	G	98.5%	G	95.5% *
31 day second or subsequent treatment – surgery	**94%**	G	99.2%	G	100.0%	G	100.0%	G	100.0% *
31 day second or subsequent	**98%**	G	100.0%	G	100.0%	G	100.0%	G	100.0%

treatment - drug									*
31 day diagnosis to treatment for all cancers	**96%**	G	98.6%	G	99.8%	G	99.6%	G	99.8% *
62 day referral to treatment from screening	**90%**	G	96.0%	G	98.6%	G	97.5%	G	96.8% *
62 days urgent referral to treatment of all cancers	**85%**	G	88.2%	G	89.3%	G	94.3%	G	90.3% *

* Cancer and Delayed Transfers of Care figures are provisional for March/Quarter 4. A&E figures are provision for quarters 1 & 2.

RAG rating for C difficile is based on the quarterly figure calculated from the annual trajectory.

A forward look

National targets remain essentially the same for 2014/15. In addition a number of local quality targets with our main Clinical Commissioning Groups have been agreed. These include CQUIN (Commissioning for Quality and Innovation) payment targets, aimed at driving up quality in certain areas:

- new to follow-up ratios
- introduction of a referral/discharge forum
- redesign of front door of A&E to include a health and social care model
- audit of appropriateness of admission
- VTE(deep vein thrombosis and pulmonary embolism)
- dementia care
- friends and family test
- a range of innovation schemes to improve patient care and experience.

5.5. External awards and recognition

Trust staff and services were the recipients of a number of prestigious awards and accolades during the year:

National recognition for diabetes education services

Buckinghamshire Healthcare Type 2 Diabetes Education Service has been awarded national recognition for providing high quality education and training for patients across the county.

The Quality Institute for Self Management Education and Training (QISMET) inspected the service and found it to meet all of their quality standards.

The QISMET certification is valid for three years and applies to the following courses delivered by a multi-disciplinary team of diabetes specialist-nurses, dieticians, physiotherapists and podiatrists:

- ‘Life and health with diabetes', for individuals with newly diagnosed Type 2 diabetes or those who have a Type 2 diabetes associated learning need and
- 'X-pert insulin', for individuals with Type 2 diabetes requiring insulin therapy

Our patients have seen a real improvement in managing their condition at home following attendance at our courses. Those who have attended a course have developed an understanding of Type 2 diabetes, gained confidence to self-manage their diabetes and maintain good quality of life.

Paralympics anniversary celebrated at Stoke Mandeville Hospital

On Thursday 29 August, the Trust celebrated the anniversary of the London 2012 Paralympic Games opening ceremony and the contribution of Stoke Mandeville Hospital in the creation of the Paralympic movement with a day of events.

The day started with an announcement made by International Paralympic Committee (IPC) President Sir Philip Craven that Stoke Mandeville would play a part in all future Paralympic torch relays.

In the afternoon, we hosted an event for visitors, staff and patients marking the unveiling of the statue of Professor Sir Ludwig “Poppa” Guttmann and the installation of a set of Agitos at the Hospital.

The Agitos (Latin for “I move”) which is the symbol of the Paralympic movement, has been installed at the entrance of the National Spinal Injuries Centre (NSIC) at Stoke Mandeville Hospital. The structure will act as a lasting reminder of the pivotal role the Hospital played in the development of the games.

The statue of Professor Sir Ludwig Guttmann, the founder of the Paralympic movement, was unveiled in his new permanent home outside the NSIC. The life-sized cast-bronze statue, which has been on display since 2012 at the neighbouring Stoke Mandeville Stadium, was conceived and commissioned by The Poppa Guttmann Trust and will act as fitting tribute to Professor Guttmann’s work at Stoke Mandeville.

6. Our staff

During 2013/14 the Trust continued to implement the People Strategy *and it’s contribution to delivery of the Trust’s mission for safe and compassionate care every time and our workforce requirements.*

The Trust is one of the largest employers in the county with a staff headcount of just over 5,700 people. During 2013/14 our numbers of directly employed staff remained broadly level throughout the first 9 months of the year, increasing in the last 3 months. This increase in the last quarter follows the Board’s agreement to an investment in the Trust’s nursing workforce of £5.1 million and the recruitment associated with this investment (see below for further details). The staff in post figure at 31 March 2014 stood at 4790 (full time equivalents).

6.1. Recruitment and retention

We are committed to recruiting and retaining the highest calibre of staff in all areas.

The annual rolling turnover figure (i.e. the percentage of staff who left the Trust) increased to 12.6% in February 2014 compared to 11.7 % February 2013, but remained significantly under the Trust benchmark of 15%.

Nurse staffing has been an area of particular focus in 2013. We conducted a Trust wide nurse staffing level review, using external assessment, and using best practice tools. The result of the review has been to confirm safe and optimum staffing levels at a ward level, and to ensure this establishment level is budgeted. This culminated in a Board decision to invest £5.1m in nurse staffing, which in a large part funded capacity increases, and responds to the recommendations of the review. In recognition of the number of nurse vacancies we have put in place a comprehensive nurse recruitment campaign. Some elements of this are detailed below:

- Open days
- Job fairs
- Overseas recruitment

Other campaign activities include

- Adverts on Arriva buses in Buckinghamshire
- New 5m x 1m banners displayed on the external walls and pull up banners displayed in the public areas of Stoke, Wycombe and Amersham Hospitals
- Regular press releases to promote open days. We have had successful coverage online and in local media of the £5m investment in nursing.
- We have been encouraging senior nurses to promote vacancies on their LinkedIn profiles
- We are using Twitter to promote Trust recruitment events; a Facebook social media campaign is being explored and is likely to be live in Summer 2013
- An improved website
- Refer a Friend promotion to be continued on the intranet, staff bulletin and with posters around the Trust
- New recruitment campaign launched. New materials are being printed

We have seen some success with this approach, and with a sustained focus on nurse recruitment and retention we anticipate a great improvement in the proportion of permanent nurse staff in post.

Our recruitment and retention work has not been limited to nursing and considerable effort has gone into recruiting doctors and people from other staff groups.

Temporary Staffing

During 2013/14, there was a continued need to use temporary staff to respond to high demand for our services, prevention and control of infection measures, sickness

absence, as well as ensure safe staffing levels on all areas. The contract with Bank Partners,(who run the Trust internal bank for nursing and administrative & clerical staff) is now in its second year and sets out key performance indicators related to quality of care, in particular through the reduction of agency usage.

Employee benefits highlights

The Trust continues to provide a range of employee benefits. These include salary sacrifice schemes for staff with childcare needs in the form of childcare vouchers, and for bike purchases as part of a cycle to work scheme. We've also teamed up with a good number of gyms and leisure centres across the county to negotiate discounted memberships for staff. The Zumba, Pilates and Yoga onsite exercise classes at Wycombe and Stoke Mandeville Hospitals are subsidised, competitively priced and in many instances delivered by our own staff.

The staff benefits pages on the new intranet provide a plethora of local and national businesses offering discounted goods and services for staff – for everything from purchasing a new car or mobile phone, to days out with the children, restaurants and beauty services.

6.2. Education, learning and development

The NHS Constitution commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed. Though the Learning and Development team and the Medical Education team, and in close collaboration with the Thames Valley Learning & Education Training Board, the Trust has worked to deliver on this objective.

The Trust's approach to the development of our people, as set out in the Education, Learning & Development Strategy, is focused around five themes:

- Leadership and Management
- Post qualification Education
- Pre qualification Education
- Vocational Learning
- Foundations for Education, Learning and Development

Ensuring our managers have the skills and competencies needed is key and has been delivered during 2013-14 through:

- Clinical Leadership: Engaging senior medical staff in the business of clinical leadership for Buckinghamshire Healthcare (BHT), focused on improving the quality of patient care. The vision is to place clinical leaders at the heart of decision making, ensuring accountability for their performance and outcomes.

- The Intermountain Leadership Programme: designed to disseminate knowledge of the 'why' and the 'how' of process management and performance improvement.
- Development of managers through leadership programmes (Bands 6 and 7), and the leadership network
- Development and roll out of a medical Leadership Development programme

- Completion of high quality appraisals at least annually to support the development of staff

6.3. Occupational health and wellbeing

Throughout the year we addressed the NHS Constitution pledge to provide support and opportunities for staff to maintain their health, wellbeing and safety.

Improving staff health and wellbeing is a Trust priority and impacts on our ability to retain staff. To support this objective, we have an established health and wellbeing steering group and Champions group representing each of the divisions of the organisation. Benefits to the business of improved staff health and wellbeing include higher productivity, increased flexibility and customer service, for example to cover for absence and holidays, raised morale, motivation, commitment and engagement, reduced absenteeism, improved recruitment and retention. To this end, the Trust has taken forward a number of initiatives including:

- Fast track physiotherapy and counselling services
- Targeted health and wellbeing for HCAs – self-care course planned for January; ward visits by OH Case Managers
- Annual health checks for staff
- A Case Manager approach to managing sickness absence

Case by case management approach to sickness

The focus on sickness absence continued across the Trust during the year, led by the HR Business Partners and the Sickness Absence Case Workers, with more staff than ever being managed informally and formally through the Trust's policies and supported by our Occupational Health and Wellbeing service. Throughout the year, sickness absence levels remained at or below the Trust's target of 3.8%. Sickness absence levels for January 2014 (the latest available) were 3.2%.

6.4. National staff survey 2013

In 2013 we participated in the 11th annual NHS national staff survey, achieving a response rate of 47% of the sampling (a reduction from 52% the previous year). There were a number of small improvements in some of the key findings over the previous year's results, but overall our results, when weighted and benchmarked, did not change significantly with the exception of two statistically significant improvements; the percentage of staff attending H&S training and the percentage of staff number receiving appraisal in the last 12 months. There were no statistically significant deteriorations.

The staff engagement score dipped to 3.56 against a national average of 3.74, with the Trust being in the bottom 20% when compared to all other Acute Trusts.

To address this we have learned from best practice at our buddy hospital, Salford Royal NHS Foundation Trust about the importance of 'engagement with a purpose'. We have therefore sought to use a variety of ways to engage with our staff around

our newly developed Quality Improvement Strategy. Examples of these initiatives include:

6.5. Consultation, negotiation and communications

The Trust recognises and has developed a positive working relationship with its trades unions, staff organisations and professional bodies over many years. We work with these bodies on a number of areas - for example organisational change, working conditions and pay, disciplinary and grievance, health and safety, harassment and bullying and improving working lives. In 2013/14, the Trust worked closely with staff side in taking forwards the actions set out the Trust's Every Patient Counts Action plan, which was drawn up following the Keogh Report.

Communications and provision of information to employees

The Trust is committed to positive two-way communications and has well defined strategies supported by robust delivery mechanisms to involve staff with clinical, service, strategic and organisational developments. Regular activities include the monthly team-briefing from the CEO or Director to ensure messages are cascaded verbally throughout the organisation, a weekly staff e-bulletin, a monthly chief executive blog and a regular staff magazine. These activities are supported through the Trust intranet, which ensures up to date information is available to all staff. In addition, during the 2013-14, the Chief Executive held coffee mornings across the Organisation; staff were encouraged to come along and ask questions about developments or changes and to share their ideas about how the care and services the Trust provides could be improved.

Whistleblowing and raising concerns

The trust commissioned an internal audit in December to review our whistle blowing procedures and the recommendations from the audit have now been built into an action plan, which included revising the policy and development of a separate procedural document and a robust tracking system. The whistle blowing and raising concerns policy underwent early review and was strengthened to reflect key legislative changes and improved monitoring and compliance.

In February 2014 the Trust set up a dedicated “Speak out safely” whistle blowing telephone message line. We also signed-up to the Nursing Times “Speaking out safely” campaign.

The updated whistle blowing poster was published in February 2014 and circulated to every department and site via the post rooms at Wycombe, Stoke Mandeville and Amersham. The poster included the details of the NED responsible for whistle blowing and raising concerns and details of the new whistle blowing telephone message line. This was also published in the staff bulletin and team brief and a communication was circulated to all divisional chairs, ACOO and ACNs during February and March 2014.

In August 2013 we issued every new junior doctor (250) with a flyer on how to raise concerns. In addition we held 3 facilitated sessions with junior doctors on raising concerns, one was run by an external facilitator and the sessions were anonymous.

Staff Recognition and Reward

As an employer we recognise the value and importance of recognising and rewarding achievement. Annually we host a Staff Awards programme which is directly connected to our Promises and Service Standards. This event, now in its 10th year, and continues to be well received within the organisation. 2013 also saw the introduction of the “Going the Extra Mile Awards” – a monthly scheme in which staff nominated by either patients or colleagues to are awarded a cash voucher by the Chief Executive as a “thank you” in recognition of their work. For the third year running, we have hosted events to recognise those staff who have achieved 25+ years of NHS service.

7. Our partners

We know meaningful involvement of those who use our services and the public benefits both our patients and the organisation. It helps us to keep the patient perspective at the heart of what we do and improves our understanding of what matters most to patients and our other partners.

Our programme of involvement activities in 2013/14 was aimed at making sure everyone with an interest in our organisation had the chance to be involved and help us shape the future direction. The following section includes the highlights.

7.1. How we involve

A membership approach

The Trust continues to maintain a membership of more than 12,000 public and staff members. Members can be as involved as much or as little as they like – with some limiting their involvement to receiving our twice-yearly newsletter and others contributing more in person through a range of different opportunities.

Key Member and public events

Our first "Healthy Child Fayre" held in Aylesbury last August was an opportunity for parents and their children to come along and see an extensive range of information stands providing key messages about child health and about the range of services we provide. The event was also an excellent launch opportunity for us to introduce parents to new information about what to do when your child is unwell in Buckinghamshire and where to access the appropriate care. The leaflets were welcomed as were expert explanations about the various urgent and non urgent paediatric journeys for treatment of common conditions and symptoms.

Parents who attended fed back they had found the event very useful and informative and the children who accompanied them enjoyed our drawing competition drawing their favourite healthy food or activity.

"Talking Francis – From Public Inquiry to Local Action", building on our earlier celebration of older people's services, this was another successful event run last year which followed up on the multiple recommendations made by Mr. Robert Francis QC, in his national report. His public inquiry into the serious failings that occurred in the Mid Staffordshire NHS Foundation Trust resulted in learning for the whole NHS. We invited patients, carers, members and the public to join us to help inform and prioritise the local actions translated from that national report.

Every Patient Counts – What do our patients say?

350 people responded to our survey, undertaken following our Keogh review to help inform our engagement programme called "A Big Conversation". (See below). We wanted to find out if our current methods and routes for engagement and involvement still meet the needs of our local community and how people want to provide feedback and share their experiences generally .

The survey was cascaded extensively and partner agencies helped to promote it with specific groups also being targeted where responses are normally low. This was a reasonable sample and provided helpful and informative feedback across a broad range of questions about involvement and experience, a few examples follow:

1. 48% said they were happy to be kept informed and happy to engage.
2. 33% reported they only wanted to be kept informed and didn't want to be involved, or engage
3. However, more than 75% told us they placed a high level of importance on our organisation engaging or involving them in areas such as local health improvements, rating it as either, extremely, very or quite important to them.
4. 64% gave us assurance we were getting things right in terms of the methods we employ to engage or involve.

5. There was an overall preference for face to face methods as opposed to non face to face methods. However, email was the most preferred option individually selected option overall
6. The desire to share an opinion or view and people's experience were seen to be the key drivers to motivate individuals to get engaged and involved.

Out and about - "A Big Conversation"

"A Big Conversation" was held across Buckinghamshire over a three month period leading into the early part of this year. Providing us with an opportunity to listen to more than 250 patient and carer experiences , we heard that generally the strongest single theme to emerge was that a clear majority of people feel the Trust provides very good clinical care but that its administrative support systems are not always as good. Their concerns focussed on a wide range of areas including the booking of appointments, delays in getting test results back to patients in a timely and efficient manner, discharge delays involving pharmacy services and disorganised patient handover between different clinical departments.

The Trust wanted to provide independent facilitation of these sessions and commissioned the Centre for Health Communication Research at Bucks New University to do this.

The Trust organised seven public meetings in locations across Buckinghamshire (Amersham, Aylesbury, Beaconsfield, High Wycombe, Bourne End, Thame and Buckingham) plus nine smaller focus group discussions which aimed to provide a smaller more comfortable environment for people to share more personal experiences of their care. In addition, we enabled people to participate online and we conducted a specific *"Big Conversation"* engagement exercise with a group of people with learning disabilities.

Each meeting focused on asking attendees to share their thoughts on the following two questions.

1) The nature of the experience that participants had (good and bad) when they were patients, carers or visitors at Buckinghamshire Healthcare NHS Trust
2) Ideas that participants had for improving the patient experience at Buckinghamshire Healthcare NHS Trust

Feedback from each of the public meetings is available via our website via (http://www.buckshealthcare.nhs.uk/abc.htm) and you can view the full report written by the Centre for Health Communication Research "*A Big Conversation (ABC) with public and patients in Buckinghamshire - Key themes and ideas for service improvements"*

Patients helping to shape what we do Training Patients for PLACE

Following last year's national launch of "Patient Led Assessments of the Clinical Environment (PLACE) the Trust is now offering an ongoing programme of training for patients and carers who would like to come and help carry out these important assessments, the results of which feed into a national publication for Trusts across the Country.

To date we have trained more than 30 members of the public and patients have been trained, many of whom are participating in this year's assessments. For more information or to know how to get involved please see our website.

"Sit and See"– dignity and compassion patients and staff working together

We are delighted to have been allowed to pilot an observational tool called "Sit and See" developed by Lynne Phair. The tool focuses on the provision of compassion dignity and respect helping inform practice and behaviours through robust observations and feedback.

Our pilot involved training clinical members of staff and patient representatives who worked together, the benefits of which were noted by both parties. We are very excited to be able to move this work forward following the success of the pilot and an ongoing programme is being developed based on the added value that this joint involvement has brought.

Adult community Health Teams (ACHTs) – Patients' views

Our Adult Community Health Team includes a range of nursing roles e.g. district nurses and physiotherapists, occupational therapists and healthcare assistants

Over 500 surveys were given out in October of last year to patients currently using the services delivered by our ACHTs with the aim of understanding what patients thought about the services that we provide.

With an overall response rate of 20%, the results are very positive, with 90% of patients rating the care received as very good or excellent. The results indicate that the service is very much valued by the patients and provides good continuity of care. The staff responsible for delivering the service have been described as approachable, compassionate and competent, with patients describing their overall experience as efficient, easy and the service as very responsive:

"I think the care is wonderful, using one's first name, listening to one's concerns, cheerful in their manner."

Feedback has helped to inform developments around the provision of the service out of hours and the development of indicators for the ongoing monitoring of this highly valued service.

Patient Experience Group (PEG)

The PEG meets every two months and continues to have representation from more than 20 patient and carer groups. It provides a valuable opportunity for input from patients and service users and for two-way dialogue. Staff representatives also attend and there is a direct link to the nursing, midwifery and therapists professional board which is chaired by the chief nurse, ensuring that the learning can be established and the necessary actions taken. Many of the PEG members are also actively involved in a variety of projects making a valuable contribution in different ways across the Trust...

The PEG continues to enjoy growth and this year we are delighted to welcome new membership of patients and carer representatives for dementia and also people with learning disabilities. This further broadens the patient perspective that the PEG brings.

PEG members provide a playing a vital role in making sure all new patient information leaflets are user-friendly by reviewing a significant number of them over past year. Their feedback and input is invaluable in helping us to maintain standards in this area.

Other examples of how we have involved our patients include:

- Becoming quality ambassadors – a newly lunched programme of being ambassadors of quality across our sites.
- Our quality walkaround
- Patient representation on a number of formal relevant committees
- A number of specific clinical and ward related projects informing changes or development e.g. our surgical ward.

Healthwatch

Healthwatch Bucks is a local branch of a national network. Healthwatch aims to be a consumer champion and wants to enable local voices to influence the delivery and design of local health and social care services. Healthwatch Bucks is a valued partner and regular meetings are held with senior members of both organisations. Healthwatch Bucks and BHT continue to work together to deliver a joint ambition of achieving the best health and social care services possible in Buckinghamshire.

Healthwatch Bucks have a number of ongoing projects working with us and other third sector partners and we look forward to working together throughout the forthcoming year.

7.2. Equality and Diversity

We have a commitment to ensure that equality and diversity is integrated at the core of our organisation.

The Public Sector Equality Duty which is placed upon all NHS Trusts provides a legal framework protecting against discrimination, promoting equality of opportunity and nurturing good relations between people who share a 'protected characteristic' and those who don't. In addition, we have also implemented the Equality Delivery System (EDS) since its launch two years ago and we are currently committed to working towards delivering the recently revised EDS2 in the early part of 2015.

Diversity is about valuing individual differences and talents, in order to create a culture where everyone can participate and thrive.

The Trust made good progress on the equality and diversity agenda over the past year. For example:

- We have collated and published a wide range of equality information to demonstrate compliance in line with our duty. Information has improved as a

result of the increased equality monitoring that we implemented in response to gaps identified in the first year as previously reported. Please see our website.

- We have met our requirement to publish our equality objectives for the third year in succession. These objectives have been developed and prioritised as a result of ongoing engagement and feedback from patients and staff. Please see our website for these and results of our last EDS assessment.
- Our staff survey has shown that for the third successive year we have increased numbers of staff undertaking equality and diversity training. This is very positive as training is an essential factor in the ongoing need to expand the breadth or understanding knowledge and awareness of this important agenda across the Trust. The past year has seen an increase in the delivery of targeted team sessions delivered face to face, in addition to the online and routine face to face training that we provide.
- Patient Experience - We have delivered our equality objective this year to implement equality monitoring onto our real time patient trackers. This means for the first time we can better understand the patient experience across groups of patients who share a protected characteristic. For example we can now begin to look at how experience of patients varies for those with a disability, those who may be lesbian, gay, bisexual or transgender or between people in different age groups e.g. older people. This is a very helpful step in having information that develops our understanding. Information is anonymous.
- Although very small, our latest workforce information, published as part of our Public Sector Equality Duty (PSED) will show that we have a year on year increase of BME staff represented in band 7 and above which was one of our original staff led equality objectives. Ongoing monitoring will continue.
- Following the introduction of EDS2, the Trust Board has approved moving the EDS to a biannual cycle of assessment to allow focus on delivery of the resulting objectives. Publication of our PSED information will move to align with our usual year end reporting timescales.
- Partnership working with Buckinghamshire County Council (BCC) and Buckinghamshire New University continues through the development of a Buckingham County Leads group hosted by BCC . The Trust is also represented at the regional leads network enabling the sharing of good practice across the NHS on this important agenda.

7.3.Charitable and voluntary services partners

The Trust is incredibly grateful to the many people who give their time for free and donations in support of improving our services for patients. They include:

- the charity **Scannappeal**, whose support this year involved the Cancer Fighting Fund, which is funding bowel screening equipment at Stoke Mandeville and digital breast screening equipment at Wycombe hospitals. Scannappeal also runs the Brain Injury Unit Appeal at Amersham and the Small Project fund, supporting projects across all our sites:

    - the **League of Friends,** working across our acute and community hospital sites
    - the **Cancer Care and Haematology Fund** at Stoke Mandeville Hospital
    - the **WRVS**, staffed almost exclusively by volunteers
    - the **Florence Nightingale Hospice Charity.**

Along with individual volunteers these groups have all made a significant contribution to helping our teams improve the experience and environment for patients.

Charitable Fund

The Trust's charitable fund is a separate legal entity (registered Charity number 1053113), which receives income consisting of donations, legacies, funds from activities and investment income. These monies are used to enhance services focused on patients' welfare, staff welfare, research and general charitable hospital purposes. The Trust Board is the corporate trustee and a separate annual report and accounts are produced for the charity, which are available from our website www.buckshealthcare.nhs.uk.

For the first time in 2013/14, accounting rules were applied which means that the Trust was required to provide both accounts in its own right and also accounts showing the consolidated results of the Charity. However, it should be emphasised that the Charity works independently of the Trust in the allocation of its resources and does not exist to subsidise NHS expenditure.

7.4 Academia and Industry - The Oxford Academic Health Science Network

The Trust is a full and active member of the Oxford Academic Health Science Network. The Network brings together a broad community of interest comprising health and social care providers, commissioners, universities and other academic groups, the third sector, life science industry and business organisations, and the public and patients within an area covering a population of 3.3 million in the Oxfordshire, Berkshire Buckinghamshire and Bedfordshire.

The purpose of the Network is to make tangible improvement to outcomes for patients and to the health of the local population: to support research and innovation; and to deliver new opportunities to support wealth creation through the UK life science industry.

The Oxford Academic Health Science Network has three major programmes and two themes in which the Trust is engaged:

Programme 1 Best care

- Best care – Clinical Networks
- Best care – Continuous Learning
- Best care – Sustainability
- Best care – Clinical Innovation Adoption

Programme 2 Research & development - working with National Institute for Health Research, Collaborations for Leadership in Applied Health Research and Care (CLAHRC), life science industry and more

Programme 3 Wealth creation - partnering with industry to support co-development, evaluation and spread of new products and services

Themes

i. Informatics

ii. Patient and Public Involvement, Engagement and Experience

8. Our estate and sustainability

The Trust remains committed to being a sustainable organisation and continued with efforts to reduce our impact on the environment throughout 2014/15.

Reducing our impact on the environment

We continued to monitor our energy and water usage through software called TEAM which can now be viewed on line. The system gives live usage readings of our electrical, gas and water consumption. We also continue to work with our PFI partners to reduce our costs and carbon usage.

We have made several improvements to reduce our electricity costs through our Combined Heat and Power (CHP) unit at Stoke Mandeville which runs on natural gas and produces electricity via an engine and hot water from the exhaust gas. This has recently been refurbished in order to maximise its contribution to this reduction in energy usage.

The Trust is now working with the Department of Health's Carbon & Energy Efficiency Fund and Schneider on a project to invest in energy saving equipment, reducing the number of temporary boilers and linking our generators to feedback to the National Grid.

All our refurbishment work during 2013/14 incorporated affordable low energy technology. With our Clinical and Medical engineering teams we sourced and installed energy efficient equipment

We are reviewing our ventilation, heating, and lighting systems in order that we can implement sustainable and affordable solutions to our sites. In partnership with our procurements team and on site partners we will develop strategies for future years.

We are working with our staff in respect of our travel plans and have renewed the contact with Arriva buses for free local transport for staff and patients to our sites. The buses recorded the use of 100,000 journeys in 2013/14.

We continue to work with clinical colleagues into less intensive models of care in order to reduce our impact on the environment.

The Carbon Reduction Committee

The national carbon reduction targets for the NHS have been set by the government

at 10 percent by 2015, followed by further target reductions of 34 percent and 80 percent by 2020 and 2050 respectively. These reductions are based on 2007 baseline data.

Our Trust has already achieved the 10 percent saving, however this is an ongoing requirement especially when the cost of CO^2 will rise from £12 per tonne to £15.60 per tonne in 2014/15.

Waste not, want not

Although we have negotiated one of the lowest rates for disposal of clinical waste within the NHS, the challenge has been to make even further improvements to waste generation through the better segregation of waste within the wards. Awareness training for staff and a new bin system has been completed as well as a new bagging system. These were all implemented by the end of 2013/14. We will see the benefits of this going forward.

The Trust is now 100 per cent recycle' in all areas, including food. We are looking at other ways we can save on waste and hope to implement those during 2015/16.

Sustainability Management Group

Sustainability Management Group members are now fully integrated into a number of other key groups that meet regularly, to ensure that this work stream is fully active in all areas of the Trust. This includes monthly meetings with our PFI partners, procurement, waste contractors, project teams, clinical staff and infection control.

For the full sustainability report please refer to appendix 17.4

8.1. Emergency planning, resilience and response (EPRR)

In line with its statutory obligations under the Civil Contingencies Act as a Category 1 responder, the Trust continues to provide a proactive and visible service for EPRR.

This last year has seen the successful implementation of plans around Olympic and Paralympic activity with close involvement by the Trust in local and national celebrations during the course of the London 2012 games.

Following a new template being issued by the strategic health authority for business continuity plans, there has been work to adapt these for Trust use. They are due to be rolled out in the first quarter of the coming year in order to ensure divisional plans are current and in line with the corporate policy.

The Trust continues to meet its requirement with regard to testing our EPRR capability and a number of multidisciplinary and whole systems practice exercises have taken place. Plans have also been tested including a clinically-led major casualty table-top exercise in which many clinical departments and senior doctors participated, and testing around the development of a regional burns major incident plan.

EPRR continues to work with and support all departments across the Trust, with

evidence of team working seen in the joint approach for the flu vaccination programme, fit test training and various communications strategies.

9. Information governance

The Trust recognises the importance of managing information appropriately and securely and has a nominated executive director as the senior information risk owner (SIRO).

The role is responsible for ensuring the Board has reliable assurance that appropriate controls are in place and that risks are managed in relation to all the information used for clinical, operational and financial purposes.

The Trust Caldicott Guardian is responsible for the establishment of procedures governing access to, and the use of, person-identifiable patient information and the transfer of that information to other bodies, where this permitted.

The Information Governance and Caldicott Committee, chaired by the Trust Caldicott Guardian, monitors the performance of the Trust against the requirements of the Information Governance Toolkit. The Trust has self-assessed its performance on information governance using version eleven of the information governance toolkit managed by Connecting for Health. In the overall information governance submission for 2013/14 the Trust achieved a score of 76% resulting in a 'satisfactory' rating. During 2013/14 Internal Audit Baker Tilly carried out an assessment of the standards in the information governance toolkit and the Trust is waiting for a final report to be issued. The draft report suggests areas to be concentrated on for 2014/15 should be in relation to data mapping and records management and these are included in the work plan for 2014/15.

The Trust continues to improve information risk controls which includes ensuring that all staff undertake mandatory annual information governance training. Regular communication to staff on information handling, information security and best practice continues to be a priority for the Trust and is supported by policies and guidance.

The Trust reported no "level two" serious untoward incidents involving personal data reportable to the Information Commissioner's Office and Department of Health. The Trust is required to follow the Health & Social Care Information Centre (HSCIC) Information Governance Serious Incidents Checklist guidance issued June 2013.

Committed to Freedom of Information

The Trust received in total 560 Freedom of Information requests in the period 1 April 2013 to 31 March 2014. This represented a 65 % increase for the same period in the previous financial year. Two requests were referred on to other organisations as information requested was not held by the Trust and four were withdrawn by the requestor. One was closed as no response was received after three months following a request for clarification. Five requests did not fall under the FOI Act and was referred to the relevant divisions.

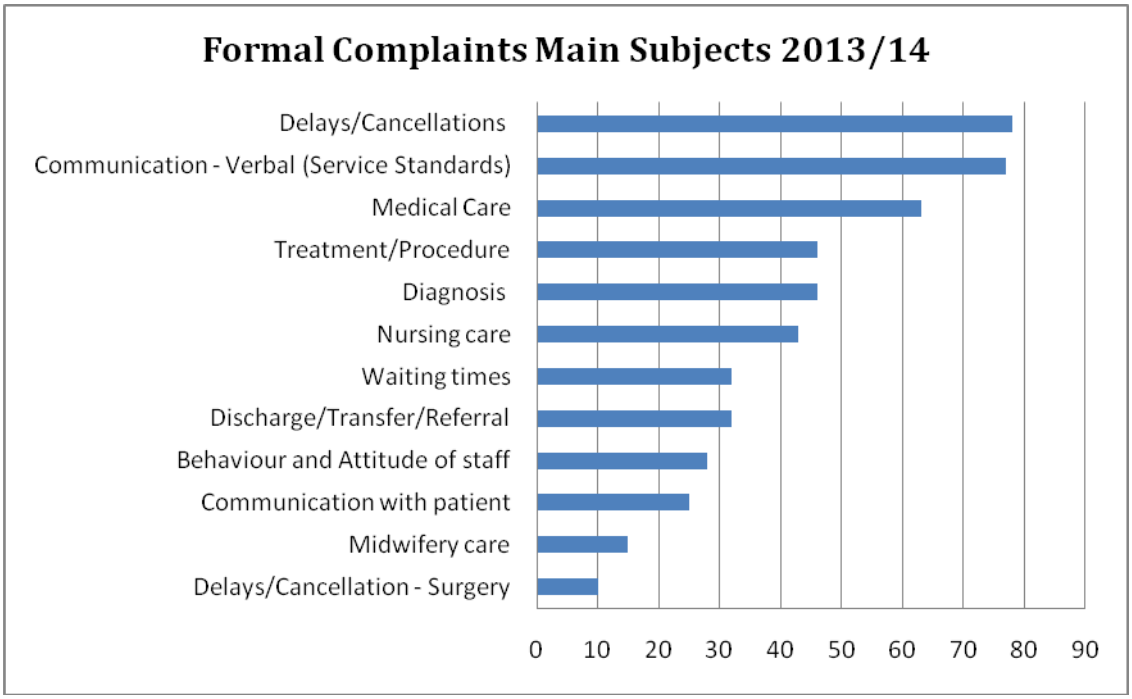
Full exemptions were applied to 22 requests where no information was provided to

the requestor and for42 other requests only part of the information was made available due to exemption.

10. Complaints and compliments

It is vitally important that the Trust learns from the experiences relayed by people through feedback, especially their complaints. This learning is identified through complaints investigations which our staff then translate into actions.

587 formal complaints were received in 2013/14. The main subjects of the complaints were as follows:



All complaints and enquiries are investigated individually. Complainants' enquiries are acknowledged in writing, and verbally when appropriate, communicating timeframes and timescales. Complainants are given a direct contact name and telephone of the assigned Complaints Officer and are offered the opportunity to discuss their complaint and how it will be handled.

Some of the actions which took place as a result of complaints are shown below:

1. Call centre review regarding outpatient booking
2. Rapid discharge process for patients on end of life pathway must include DNACPR review
3. All stock levels of ERCP kit are now confirmed every Monday (the ERCP list is on a Thursday) and a system that ensures the endoscopists are informed of any lack of kit ahead of time.
4. Ensure adequate and broad knowledge of signs, symptoms and management of patients with possible necrotising fasciitis. This will be facilitated by including necrotising fasciitis in the emergency department teaching programme.

5. Ensure that the learning disabilities nurse is informed of all admissions.
6. Option to pay for photos by card in the ultrasound dept at WGH, more cards purchased and replenish the machine throughout the day.
7. Flow chart with agreed pathway for breast Care patients to be devised, agreed by all parties and circulated to all staff.

We also receive thousands of compliments every year which are sent through to the corporate office and to wards and departments. In the past year we have received approximately 7,000 compliments.

In March 2014 we launched new patient feedback website www.buckshealthcare.nhs.uk/feedback

10.1. Principles for remedy

The Ombudsman's "Principles for Remedy" state that an attempt to resolve a complaint should be based on:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

The Trust makes every effort to comply with these principles. We are always ready to apologise where our service has not been what the service user expected, and to put things right for complainants as promptly and appropriately as possible. Our aim is to use the lessons learned from complaints to make sure that we do not make the same mistakes again.

11. Our Trust Board

The Trust Board provides strategic leadership to the organisation. It sets the strategic direction, ensuring management capacity and capability, monitoring and managing performance and fosters the appropriate culture.

It outlines the vision of the organisation and champions and safeguards its values, keeping the safety of patients at the centre of its work and ensuring obligations to all key stakeholders are met. By ensuring the effective and efficient use of resources it safeguards public funds.

Non-executive and executive directors both have responsibility to constructively challenge the decisions of the Board. Non-executive directors have a particular duty to hold the executive directors to account, ensuring appropriate challenges are made. As well as bringing their own expertise to the Board, non-executive directors scrutinise the performance of management in reaching goals and objectives, and monitor the reporting of performance. They need to satisfy themselves as to the quality and integrity of financial, clinical and other information, and ensure that the financial and quality controls of risk management are robust.

11.1. Directors and the register of interests

The register is maintained by the head of the executive office who holds the original signed declaration forms. These are available for inspection by contacting the head of the executive office on 01494 734851.

Name	Position	Interests Declared
Les Broude	Non-Executive Director	Works on a consultancy basis on career transition with Penna Plc. The work involves coaching people coming out of the public and private sectors; some work has been done in the past with NHS Buckinghamshire. Family friend Chair of The Royal Hospital for Neuro-Disability. Family friend NED at the Oxford Health NHS Foundation Trust. Son is Head of Procurement for Care UK Healthcare Division (declared 14-08-13).
Juliet Brown	Director of Strategy & System Reform	Director and Secretary for Shining Life Children's Trust (Charitable Co) charity involved in social work in Sri Lanka
Dr Kathy Cann[1]	Medical Director	None
Neil Dardis	Chief Operating Officer and Deputy Chief Executive	None
Anne Eden	Chief Executive	Visiting Professor Bucks New University
Ian Garlington[2]	Director of Property Services	Director The Stoke Mandeville Hospital Postgraduate Society Ltd Trustee of the National Society for Epilepsy Trustee of Scannappeal Partner works for GV Health Ltd
Keith Gilchrist	Non-Executive Director	Advisory work with LCA (low carbon technology) and other printing industry financial funds for start up/development companies. Son is Doctor STR Oxford JR paediatrics and will be clinical research fellow Oxford Deanery after Sept 2013.
David Griffiths[3]	Associate NED	None
Malcolm Griffiths	Non-Executive Director	Director of Okio Limited, an IT/web design company Director of Bluespace Thinking, a consultancy

Name	Position	Interests Declared
		company Chair of the South Central Patient Safety Federation
Fred Hucker [4]	Chair	Trustee, Dipex Oxford
Graeme Johnston	Non-Executive Director designate	Chair of a health charity trustees (NRAS); Member of local PPG (chair); Member of Aylesbury vale CCG (north locality) patient engagement group; Member of the scientific advisory board for immunology for UCB Pharmaceuticals of Belgium for which I receive a small honorarium.
Helen Keenan	Non-Executive Director	Managing Director and owner of Helen Keenan by Design Ltd, a childrenswear design and retail company with no connection to the NHS.
Dr Tina Kenny[5]	Medical Director	None
Brenda Kersting[6]	Non-Executive Director	Lay Assessor for the National Clinical Assessment Service (NCAS) Independent Member of the Parole Board Non Executive Member of Parole Board Audit and Risk Committee Lay Fitness to Practice panellist for the Medical Practitioners Tribunal Service.
Hattie Llewelyn-Davies[7]	Chair	Chair Viridian Housing Group (merging with Asra Housing Group w.e.f. 01-06-14 to become Viridian Asra Housing Group). Directors' fees payable of £15k p.a. Owner/Director of consultancy business that does not undertake work with the NHS but may advise organisations that do. *Added 03-02-14*
Dr Graz Luzzi[8]	Medical Director	External specialist consultant to Oxfordshire Clinical
Anne Robson[9]	Interim Director of Human Resources & OD	Director of Interims Limited
David Sines	Non-Executive Director Designate	Director of the British School of Osteopathy Pro Vice Chancellor at Buckinghamshire New University with educational contracts with the SHA

Name	Position	Interests Declared
		Lead Host Director of the Thames Valley HIEC Director of the British School of Osteopathy NED – Central London NHS Community Healthcare Trust PVC with responsibility for educational contracting with the Trust via NHS South of England Bucks University Executive Board member of INSTAL
Lynne Swiatczak[10]	Chief Nurse & Director of Patient Care Standards	Visiting Professor Bucks New University, Faculty of Health and Social Care
Tom Travers	Director of Finance & IT	None
Mark Warner[11]	Director of Human Resources and Organisational Development	None
Clinton Green[12]	Director of Property Services	None

1. Dr Cathy Cann (June to 31 October 2013)
2. Ian Garlington (to 30 September 2013)
3. David Griffiths (from 15 January 2014)
4. Fred Hucker (to 31 December 2013)
5. Dr Tina Kenny (from 1 November 2013)
6. Brenda Kersting (acting Chair 1 December 2013 to 18 March 2014)
7. Hattie Llewelyn-Davies (from 19 March 2014)
8. Dr Graz Luzzi[8] (to June 2013)
9. Anne Robson (to July 2013)
10. Lynne Swiatczak (to 25 March 2014)
11. Mark Warner (from 15 August)
12. Clinton Green (from 1 October 2013)

11.2. Remuneration report

Directors' remuneration

The Secretary of State for Health determines the remuneration of the chairman and non-executive directors nationally. Remuneration for executive directors is determined by the Trust's nominations and remuneration committee.

The nominations and remuneration committee is made up of all the non-executive

directors and is responsible for agreeing the remuneration of the executive team and senior managers who are not subject to Agenda for Change. The committee reviews the pay of executive directors annually taking into account prevailing factors such as national pay rises and salaries paid by other NHS employers.

The executive directors are employed within a standard employment contract which provides for a six month notice period. On termination of employment the director would be entitled to contractual severance terms, such as lieu of notice pay and redundancy.

The non-executive directors are appointed for a set term of office. Their original date of appointment, date of expiry and extended date of tenure (if applicable are set out below:

Name	**Date of Appointment**	**End of Term of office**	**Extension to tenure (if applicable)**
Fred Hucker	01/10/2012	Retired 31/12/2014	
Les Broude	01/05/2007	30/04/2011	30/04/2015
Brenda Kersting	01/05/2007	30/04/2011	30/06/2014
Keith Gilchrist	01/05/2007	30/04/2011	30/04/2014
Malcolm Griffiths	16/07/2007	15/07/2011	30/04/2014
Helen Keenan	07/03/2013	31/03/2017	

There are no rolling contracts, nor is there any performance related pay for any director.

In 2013/14 there have been no significant awards or compensation payments made to past directors, and no amounts are payable to third parties in respect of any director.

Membership of the nominations and remuneration committee during 2013/14:

Fred Hucker (to 31/12/14)

Les Broude

Keith Gilchrist

Malcolm Griffiths

Brenda Kersting

Helen Keenan

Full details of directors' remuneration and pension benefits are given below:

	2013-14					2012-13				
Name and Title	Service as Director in year	Salary (bands of £5000) £000	Expense Payments (taxable)* total to nearest £100 £00	All pension related benefits (bands of £2,500) Rounded to the nearest £100 £000	Total (bands of £5000) £000	Service as Director in year	Salary (bands of £5000) £000	Expense Payments (taxable) total to nearest £100 £00	All pension related benefits (bands of £2,500) Rounded to the nearest £100 £000	Total (bands of £5000) £000
Chairman										
Mr F Hucker	1/4/13 to 31/12/13	25-30			25-30	1/10/12-31/3/13	15-20	-		15-20
Mrs B Kersting	1/1/14 to 18/3/14	10-15			10-15	1/4/12-30/9/12	10-15	-		10-15
Mrs H Llewelyn-Davies	19/3/14 to 31/3/14	0-5			0-5					
Non-Executive Directors										
Mr M Griffiths	Full Year	5-10	-	-	5-10	Full Year	5-10	-		5-10
Mr L Broude	Full Year	5-10	-	-	5-10	Full Year	5-10	-		5-10
Ms H Keenan	Full Year	5-10	-	-	5-10	7/3/13 - 31/3/13	0-5	-		0-5
Mr K Gilchrist	Full Year	5-10	-	-	5-10	Full Year	5-10	-		5-10
Mrs B Kersting	1/4/13 to 31/12/13	0-5	-	-	0-5	1/10/12-31/3/13	0-5	-		0-5
Associate Non-Executive Director										
Prof D Sines	Full Year	5-10	-	-	5-10	1/4/12-31/3/13	5-10	-		5-10
Mr G Johnston	Full year	5-10	-	-	5-10		0-5			0-5
Mr D Griffiths	15/1/14 to 31/3/14	0-5	-	-	0-5					
Chief Executive										
Ms Anne Eden	Full Year	155-160	18	-	155-160	Full Year	155-160	16		155-160
Chief Operating Officer										
Mr N Dardis	Full Year	125-130	-	102.5-105	230-235	1/2/13 - 31/3/13	20-25	-		20-25
Director of Finance										
Mr T Travers	Full Year	120-125	13	25-27.5	150-155	Full Year	110-115	12	25-27.5	145-150
Chief Nurse and Director of Patient Care Standards										
Ms L Swiatczak	Full year	90-95	-	10-12.5	105-110	Full year	95-100	-	15-17.5	110-115
Medical Director										
Dr G Luzzi**	1/4/13 to 31/5/13	20-25	-	**	20-25	Full Year	175-180			175-180
Dr K Cann	1/6/13 to 31/10/13	55-60	-	-	55-60					
Dr T Kenny	1/11/13 to 31/3/14	65-70	-	-	65-70					
Director of Property Services										
Mr I Garlington	1/4/13 to 6/10/13	50-55	-	17.5-20	70-75	Full Year	105-110	8	25-27.5	130-135
Mr C Green	7/10/13 to 31/3/14	80-85	-	-	80-85					
Director of HR and organisational development										
Ms A Robson	1/4/13 to 30/6/13	75-80	-	-	75-80	1/2/13-31/3/13	35-40			35-40
Mr M Warner	1/7/13-31/3/14	70-75	-	7.5-10	80-85					
Director of Strategy & System Reform										
Mrs J Brown	Full year	65-70	-	5-7.5	70-75	Full year	60-65	-	12.5-15	70-75

*Expense payments relate to the provision of a lease car that is also available for private use.

** As Dr Luzzi was in post for one part of the year, the real pension related benefits figure does not compute correctly to be of relevance.

Name and Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	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's Contribution to stakeholder pension**
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100 £
Chief Executive Ms A Eden	0-2.5	0-5	60-65	190-195	1,277	1,203	41	-
Chief Operating Officer Mr N Dardis	5-10	16-20	25-30	80-85	372	289	63	-
Director of Finance Mr T Travers	0-2.5	5-7.5	20-25	65-70	399	348	32	-
Director of Nursing Ms L Swiatczak	0-2.5	2.5-5	5-10	25-30	187	159	14	-
Director of HR and Organisational Development Mr M Warner***	-	-	0-5	-	10	-	1	-
Director of Strategy & System Reform Mrs J Brown	0-2.5	0-2.5	15-20	45-50	250	229	10	-
Director of Facilities and Estates Mr I Garlington ***	0-2.5	-	5-10	-	93	76	9	-

* The Real Increase In Cash Equivalent Transfer Value is net of employee contributions to the pension scheme.

**There have not been any contributions to a stakeholder pension scheme by the Trust

*** These Directors are members of NHS Pension Scheme 2008 section and are therefore not entitled to a lump sum.

Dr Luzzi was only in post for part of the year so real increases in benefits do not compute correctly.

This table only includes Executive Directors where the Trust has made contributions to a pension scheme.

Pay multiples

From 2013/14, reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Buckinghamshire Healthcare NHS Trust in the financial year 2013/14 was £155,000 to £160,000 (2012/13 £155,000 to £160,000). This was 5.6 times (2012/13 5.6 times) the median remuneration of the workforce, which was £28,002(2012/13 £28,039).

In 2013/14, 11 employees (2012/13 nine employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £158,000to £209,000 (2012/13 £158,000 to £178,000).

Total remuneration includes salary, non-consolidated performance-related pay (none awarded in 2012/13 or 2013/14) benefits-in-kind and any severance payments. It does not include employer pension contributions and the cash equivalent transfer values of pensions. None of the employees who received remuneration in excess of the highest paid director received redundancy payments in 2013/14 (2012/13 nil).

There was a pay freeze across the NHS during 2010/11 to 2012/13, and a 1% pay increase awarded for 2013/14.

'Off Payroll' employees

The 'Review of Tax Arrangements of Public Sector Appointees' was published by the HM Treasury in 2012, which was followed up with its Annual Reporting Guidance in December 2012. This requires the Trust to have in place contractual arrangements that allow it to assure itself of the tax arrangements of those people employed by the Trust, but not through payroll, for a period of more than six months at a cost of more than £220 per day.

The Trust is required to provide disclosures on how many of those arrangements it had in place at 31st March 2014, and new engagements during the period 1st April 2013 to 31st March 2014..

Table 1	Number
Number of existing engagements as of 31 March 2014	5
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	3
Number of new engagements which include contractual clauses giving the Buckinghamshire Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0

Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

All off payroll engagements are subject to a risk assessment as to whether assurance is required on the individual's tax affairs.

In addition the Trust is required to provide the disclosure in the table below regarding the number of board members or managers with financial responsibility employed on such a basis.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	4
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	76

Audit committee

The directors who were members of the audit committee during the year were:

Les Broude (Chair)	Non-Executive Director
Keith Gilchrist	Non-Executive Director
Malcolm Griffiths	Non-Executive Director
Brenda Kersting	Non-Executive Director (to December 2013)

Auditors

Ernst and Young are appointed to provide external audit services to the Trust.

The scale fees for 2013/14 were set at £121,720 plus VAT.

The Audit Commission provides specific pieces of work, such as the National Fraud Initiative work, to the Trust.

Directors' declaration in respect of audit

In line with current guidance, each director has given a statement that, as far as they are aware, there is no relevant audit information of which Ernst and Young (the

Trust's auditors) is unaware. Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information, and to establish that Ernst and Young is aware of that information.

12. Our financial performance

Our objective is to deliver quality services while achieving value for money ensuring economy, effectiveness and efficiency in the use of our resources.

12.1. Improving financial management to deliver better value for money

The commissioning landscape for NHS services was altered significantly following the Health and Social Care Act 2012. The Trust's main commissioner had previously been NHS Buckinghamshire and responsibility for commissioning these services now passed to Clinical Commissioning Groups (predominately Aylesbury Vale and Chiltern CCGs), NHS England through Local Area Teams (Thames Valley and Wessex) and the County Council..

Within the calculation of the amount the Trust is paid for its services is a built-in understanding that it will make efficiency savings of 4% per annum. This, together with an assumption that the level of referrals are expected to reduce as more patients are seen in the community or primary care, resulted in a need to make efficiency savings of £24.4m in 2013/14 to meet the planned surplus of £5.0m. Business pressures in year, which are considered in more detail below, meant that the Trust realigned its forecast surplus to £0.3m and identified a Recovery Plan on the delivery of savings.

Continued operational pressures meant that the Trust succeeded in delivering savings of £21.6m, £2.8m behind plan. However, as the operational pressures were caused, in part, by the non-reduction of referrals to the level anticipated, the Trust received more income than was forecast. This, together with the huge amount of work took place in driving down cost, helped the Trust to attain a surplus of £0.3m. As a result, the Trust has managed to 'breakeven' for the past six years.

Ernst and Young, the Trust's external auditors, consider whether the Trust has put into place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as part of the audit work it carries out on the Trust. Although in previous years, the Trust had an unqualified opinion in this area, in 2013/14 Ernst and Young qualified their opinion.

The Trust has experienced a financially challenging year and had succeeded in reporting a small surplus. However it had not delivered its planned surplus or delivered its Cost Improvement Programme in the way that it originally forecast. The auditors need to consider the financial resilience of the Trust and concluded that there are risks in this area in the short to medium term.

The Trust had already ensured that it had discussed its plans for 2014/15 in depth with the Trust Development Agency to ensure that these are realistic and achievable. This will help to ensure that the Trust manages its financial risks and opportunities through its governance systems and processes in order to secure a stable financial position.

12.2. The efficiency programme

The Trust continued to face a significant financial challenge in 2013/14 that required delivery of £24.4 million efficiency programme. Meeting the statutory requirement to balance the costs and income resources was achieved in 2013/14 in the context of ensuring clinical and patient safety and overall quality was sustained. Underpinning our efficiency effort was close work with the wider healthcare economy alongside continuing to develop a programme of work that stretches into 2016/17 to help provide a clear longer term platform of improvement. The Trust needs to ensure that the future delivery of savings is on a recurrent basis.

2013/14 saw the Trust continue to deliver efficiencies in the support areas of procurement, estates, corporate and back office/technology support, whilst operating a balanced set of efficiency judgements around patient and clinical areas mainly focused on continuing to drive to down the costs of more expensive temporary staff and replacing these with permanent workforce. Overall the demand for BHT services was such that additional income was supported, and efficiencies gained, by delivering this patient care through smarter use of existing resources rather than needing to resort to larger scale recruiting increased staff in a very challenging recruitment market.

12.3. Performance in-year

In planning its income for 2013/14, the Trust needed to take into account the effect on income of the local health economy's need to reduce demand on acute services in order that more patients could be treated at home with the aid of primary care and community services. In addition, a 4% efficiency saving was inbuilt into the tariff on which the Trust obtains payment for activity.

The Trust had worked with the local economy in 2012/13 to restructure health services through the Better Healthcare in Bucks (BHiB) strategy. This, together with the reorganisation of emergency services through the Minor Injury and Illnesses Unit (MIIU) at Wycombe, A&E at Stoke Mandeville and the Surgical Floor at Stoke Mandeville should have reduced the overall level of activity and removed cost from the Trust.

However the Trust continued to see high levels of referrals and hence demand for services, which translated into the receipt of income from commissioners £22.2m above the level that had been foreseen in the original signed contracts between the Trust and its commissioners.

The Trust needed to invest heavily in staff and other costs to ensure that these additional services could be provided in a way to ensure quality, safety and the positive experience of patients. This was also combined with the focus on the quality of care and delivery of the improvements identified within the 'Every Patient Counts' programme. These pressures, when combined with winter issues, norovirus and recruitment issues meant that the Trust spent £12.5m over plan on staffing costs, with a significant amount on temporary staffing.

Despite these challenges, the Trust achieved a surplus, after technical adjustments, of £320,000. This achievement means that the Trust has continued to succeed in its

duty to ‘breakeven’ on a cumulative basis – a requirement in its aspiration to achieve Foundation Trust status.

The position reported before technical adjustments is a surplus of £5,229,000 However, there are three items included within this that the Department of Health requires to be negated before considering the financial performance of a Trust. These items are:

- reversal of an impairment to the value of the Trust’s property that had previously been reflected in the Statement of Comprehensive Income (SOCI). During 2013/14, the Trust obtained an interim valuation on the value of the Trust’s specialised buildings. This showed that asset values had risen, on average, by 5% in year. Although this was offset, in part, by the value of expenditure on the building fabric to change service provision not being fully reflected in its revised value, an overall impact in asset value changes through the SOCI of £2,876,000 was generated. This is considered to be outside the financial management of the Trust and to artificially deflate the performance reported. The effect of this on the surplus needs to be removed.

- The impact of the change in accounting treatment for the Stoke Mandeville PFI (Private Finance Initiative) as a result of the transition to International Financial Reporting Standards (IFRS). This caused the reported surplus in 2013/14 to be £2,070,000 higher than it would otherwise have been, so also needs to be removed..

- The impact of the change in accounting treatment for donated assets in 2011/12. This had the impact of reducing reported performance in 2013/14 by £37,000 and, therefore, needs to be added.

The net effect of these three adjustments is to adjust the £5,229,000 surplus to the reported £320,000 surplus against which the Trust is assessed.

The Trust is required to meet, or undershoot, certain targets known as ‘External Financing Limit’ and ‘Capital Resource Limit’. In 2013/14 the Trust achieved these targets within acceptable levels.

Expense recognition

In 2013/14, there were a number of service redesigns and restructurings that took place throughout the Trust. As a result, a number of staff were made redundant. The number of staff affected and the value of their exit packages is shown below. All exit packages were within contractual terms and no additional non-contractual payments were made.

Exit package cost band (including any special payment element)	Number and cost of compulsory redundancies	Number and cost of other departures agreed	Total number and cost of exit packages	Number and cost of departures where special payments have been made
Less than £10,000	2 £15,258		2 £15,258	0 £0
£10,000 - £25,000	2 £25,354		2 £25,354	0 £0
£25,001 - £50,000	1 £42,790		1 £42,790	0 £0
£50,001 - £100,000				0 £0
£100,001 - £150,000				0 £0
£150,001 - £200,000				0 £0
>£200,000				0 £0
Total	5 £83,402		5 £83,402	

Non-current assets

Legacy balance transfers.

In accordance with the Health and Social Care Act 2012, Strategic Health Authorities and Primary Care Trusts were dissolved on 1 April 2013 and their assets and liabilities transferred to successor bodies in the NHS or to other entities. Under the terms of the Buckinghamshire Primary Care Trust Property Transfer Scheme (a) and its supporting Schedules, a number of assets and liabilities were transferred from Buckinghamshire Primary Care Trust (NHS Buckinghamshire) to the Trust on that date.

This transfer consisted of the land, buildings and equipment associated with the Community Hospitals, which had a total value of £17.9m. This value has been included within the Property, Plant and Equipment valuation shown in the Trust's financial schedules.

There were also creditors outstanding and due to be paid for works on these properties of £2.1m, of which £1.9m was owing to the Trust. This was settled by NHS England early in 2013/14 by the transfer of Public Dividend Capital.

These assets and liabilities are associated with the transfer of the provision of community services, which the Trust was commissioned to provide from 1st April 2010. In the period 2010 to 2013 the Trust leased the properties from NHS Buckinghamshire.

The accounting arrangements in respect of these transfers are outlined in Note 1. 3 to the Annual Accounts.

Existing assets

The Trust is required to report the 'fair value' of its non-current assets. In assessing the fair value, it takes into account the advice of experts, where appropriate. The District Valuation Office has produced an interim valuation of the Trust's properties at 31st March 2014. The Trust will commission a full valuation at 31st March 2015, the five-year anniversary of its last full revaluation. The interim valuation resulted in an increase, on average, of approximately 5% on the value of the properties.

Where property value decreases have previously been charged through the Statement of Comprehensive Income, the 'first call' on any valuation increase is to reverse the previous decrease. If this did not happen, or has been fully reversed, any residual increase is taken to the Revaluation Reserve.

The Trust is not aware of any material differences between the carrying value of its properties and their market value in their current condition.

Donations

We were extremely fortunate again in 2013/14 to benefit from support from Scannappeal, the Trust charities and the League of Friends; with the purchase of medical and other equipment exceeding £1,269,000. There have also been donations of smaller items of equipment for which we are extremely grateful.

In addition to the purchase of medical equipment, the Trust receives support from the charities in a number of other areas, including enhancing the environment for patients and supporting staff in training and health &wellbeing.

Depreciation of donated assets in the year was charged at £1,303,000. The excess of depreciation over the value donated is considered to be a 'technical adjustment' to the Trust's reported performance.

Pension liabilities

Past and present employees of the Trust are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme and is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the

scheme is equal to the contributions payable to the scheme for the accounting period. Further details can be found in note 9 of the Trust's 2013/14 financial statements.

Financing arrangements

At the beginning of 2013/14, the Trust had three loans. The first is a capital loan which was taken out in September 2008, at a fixed interest rate of 4.88%, in order to support the Trust's significant capital programme in that year. The final repayment against this loan of £700,000 was made in September 2013 in line with the scheduled repayments. The second is a working capital loan, which was taken out in March 2010. This loan is at a fixed interest rate of 1.89% and, at 31st March 2014, there was £2,500,000 outstanding. This is repayable in twice yearly instalments of £1,250,000 in September and March, and is due to be fully repaid in 2014/15.

In March 2013, the Trust received a Revenue Support Loan in preparation for its application to become a Foundation Trust. This loan, of £8,000,000, is repayable over seven years in twice yearly instalments of £571,000 (September and March).

During the financial period, the Trust incurred £170,000 (2012/13 £210,000) in interest on its loans.

During 2013/14 the Trust received £10,000,000 in temporary borrowing from the Department of Health, which was fully repaid in March 2014. At the same time as the repayment, it received permanent Public Dividend Capital of £5,000,000 to support its working capital. This is not repayable or interest-bearing. It also received Public Dividend Capital of £2,953,000 in 2013/14 as funding against specific investments in improvements to birthing environments and technology.

Under IFRS, the Trust is required to account for the Private Finance Initiative (PFI) schemes and any equipment held under finance leases by accounting for both the value of the asset and the future liability to pay. This future liability is shown on the Statement of Financial Position as 'borrowings'. The amount paid to our PFI partners is accounted for as either service charges for the services provided, or finance charges on the 'borrowing' for the buildings in the Income Statement. In 2013/14 the Trust accounted for £11,604,000 (2011/12 £10,374,000) in finance charges in relation to the PFIs.

Cash flow

The Trust had a year end cash balance of £1.5m. It is required to manage its cash in order to meet, or 'undershoot', its External Financing Limit (EFL). The Trust underspent against its EFL by £0.5m in 2013/14

The Trust actively manages its operational cash flows by pursuing its debt in order to minimise amounts outstanding and by paying its creditors as they fall due.

The Trust's loan arrangements are discussed under 'Financing Arrangements' above.

The Trust has modelled its future cash flows in order to meet its financing obligations and capital expenditure requirements, and these form the basis of its cash management strategy.

The Trust earns interest on its bank balances and is subject to interest rate fluctuations on these earnings. Interest rates are currently very low, so the risk of them reducing by a material amount and thus reducing the Trust's income earned is also considered to be low. The Trust's loans are at fixed interest rates so the Trust is not exposed to interest rate risk in respect of loans.

Interest earned on bank balances during the year amounted to £37,000 (2011/12 £33,000).

Better payment practice code

The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid NHS and non-NHS trade creditors by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance in 2013/14 shown below:

	2013-14 Number	**2013-14 £'000**	2012-13 Number	2012-13 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**62,868**	**156,876**	63,905	172,770
Total Non-NHS Trade Invoices Paid Within Target	**52,264**	**142,281**	52,759	157,426
Percentage of NHS Trade Invoices Paid Within Target	**83.13%**	**90.70%**	82.56%	91.12%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,498**	**52,334**	3,184	**53,160**
Total NHS Trade Invoices Paid Within Target	**1,661**	**47,218**	2,298	**45,467**
Percentage of NHS Trade Invoices Paid Within Target	**66.49%**	**90.22%**	72.17%	85.53%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The Trust is working to improve its performance under the Better Payments Practice Code, which requires that 95% of undisputed invoices should be paid within 30 days of receipt. Further efforts will be made in 2014/15 to improve the percentage achieved.

Compliance with setting charges for information

The Trust is compliant with the Treasury's guidance on setting charges for information which can be found under http://www.hm-treasury.gov.uk/psr_mpm_annexes.htm

12.4. 2014/15 and beyond

The financial challenges for 2014/15 look as considerable as those for previous years. Investment in technology, such as mobile working practices and wireless communications will help the Trust to deliver its services in the most effective way, ensuring that the capacity in our services is available to meet the demands being placed on them.

The Trust will be continuing to work with the Trust Development Authority on securing a permanent solution on its ongoing liquidity issues, to help to secure future financial sustainability.

The Trust has worked with its commissioners in agreeing contracts for activity levels in 2014/15. It will continue to invest in recruitment of permanent staff in pressure areas, such as nursing and certain medical specialities, to improve quality and reduce the requirement for higher cost temporary staffing.

The Trust continues to pursue its aspiration to be a Foundation Trust through the development of its Long Term Financial Model and Integrated Business Plan. It expects to be considered as an applicant Trust once special measures on performance and quality monitoring have been removed.

2015/16 sees the move to the ‘Better Care Fund’, which seeks to ensure that resources are available within appropriate care settings as close to the patients’ homes as possible, to remove patients from the acute hospital care, which is better for their long term treatment and management.

Statement of Comprehensive Income for year ended

31 March 2014				**Consolidated**	Consolidated
	NOTE**	**2013-14 £'000**	2012-13 £'000	**2013-14 £'000**	2012-13 £'000
Gross employee benefits	9.1	**(215,963)**	(212,040)	**(215,963)**	(212,040)
Other operating costs	5	**(121,244)**	(130,895)	**(122,294)**	(134,248)
Revenue from patient care activities	4	**336,551**	320,668	**336,551**	320,668
Other Operating revenue	5	**22,898**	30,253	**24,364**	33,959
Operating surplus/(deficit)		**22,242**	7,986	**22,658**	8,339
Investment revenue	11	**37**	33	**259**	227
Other gains and (losses)	12	**0**	894	**0**	894
Finance costs	13	**(11,854)**	(10,665)	**(11,854)**	(10,665)
Surplus/(deficit) for the financial year		**10,425**	(1,752)	**11,063**	(1,205)
Public dividend capital dividends payable		**(5,196)**	(5,450)	**(5,196)**	(5,450)
Retained surplus/(deficit) for the year		**5,229**	(7,202)	**5,867**	(6,655)

Other Comprehensive Income	**2013-14 £'000**	2012-13 £'000	**2013-14 £'000**	2012-13 £'000
Impairments and reversals taken to the Revaluation Reserve	**0**	(1,524)		(1,524)
Net gain/(loss) on revaluation of property, plant & equipment	**4,141**	0	**4,141**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0	**255**	796
Total Comprehensive Income for the year*	**9,370**	(8,726)	**10,263**	(7,383)

*Retained surplus/(deficit) plus Other Comprehensive Income

** Notes relating to the Consolidated results are contained within Note 39 to the Accounts

Financial performance for the year	**£'000**	£'000
Retained surplus/(deficit) for the year	**5,229**	(7,202)
IFRIC 12 adjustment (including IFRIC 12 impairments) (see note a below)	**(2,070)**	1,153
Impairments (excluding IFRIC 12 impairments) (see note b below)	**(2,876)**	6,689
Adjustments in respect of donated asset reserve elimination (see note c below)	**37**	(341)
Adjusted retained surplus/(deficit)	**320**	299

The financial performance of an NHS Trust is based on its retained surplus or deficit for the year which is adjusted as below. It is not based on the Consolidated results with its associated Charity shown above.

a) The revenue costs of bringing PFI assets onto the Statement of Financial Position due to the introduction of International Accounting Standards (IFRS) accounting in 2009/10

NHS Trusts' financial reporting performance measurement needs to be aligned with the guidance by HM Treasury measuring departmental expenditure. Therefore the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact, and is therefore not chargeable for overall budgeting purposes, should be reported as technical. The additional cost is not considered part of the organisation's operating position.

b) Impairments to the value of Non-Current Assets and Reversals

Movements in the value of non-current assets, caused by such factors as fluctuations in the property market or as a result of valuation methodology, are not considered to be part of an organisation's operating position.

c) Change in accounting policy in respect of donated assets

HM Treasury issued new guidance in 2011/12, which stated that donated assets will be recognised in full in the SOCI in the year of receipt. Any difference between receipt and depreciation charged on donated assets is recorded as a technical adjustment.

PDC Dividend Receivable/Payable

	£'000
PDC dividend: balance receivable/(payable) at 31 March 2014	**(190)**
PDC dividend: balance receivable/(payable) at 1 April 2013	**118**

Note 1.4 to the Accounts provides information on the Consolidated Trust and associated Charity figures above. NHS financial performance is not measured on the Consoliated position

The notes on pages 5 to 41 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	**31 March 2014**	31 March 2013	**Consolidated 31 March 2014**	Consolidated 31 March 2013	Consolidated 1 April 2012
		£'000	£'000	**£'000**	£'000	£'000
Non-current assets:						
Property, plant and equipment	14	**281,248**	253,564	**281,248**	253,564	261,617
Intangible assets	15	**1,345**	524	**1,345**	524	191
Other Investments - Charitable				**7,495**	7,240	4,445
Trade and other receivables	20	**2,249**	2,397	**2,249**	2,397	2,545
Total non-current assets		**284,842**	256,485	**292,337**	263,725	268,798
Current assets:						
Inventories	19	**5,525**	5,023	**5,528**	5,028	4,722
Trade and other receivables	20	**22,819**	16,506	**21,805**	16,349	18,696
Other current assets	21	**147**	148	**147**	148	147
Cash and cash equivalents	22	**1,519**	2,779	**4,443**	5,321	8,339
Total current assets		**30,010**	24,456	**31,923**	26,846	31,904
Non-current assets held for sale	23	**0**	0	**0**	0	1,800
Total current assets		**30,010**	24,456	**31,923**	26,846	33,704
Total assets		**314,852**	280,941	**324,260**	290,571	302,502
Current liabilities						
Trade and other payables	24	**(29,987)**	(23,759)	**(28,951)**	(23,838)	(32,041)
Other liabilities	25	**(25)**	(97)	**(25)**	(97)	(26)
Provisions	29	**(512)**	(1,473)	**(512)**	(1,473)	(234)
Borrowings	26	**(2,049)**	(1,871)	**(2,049)**	(1,871)	(1,704)
Working capital loan from Department	26	**(3,642)**	(3,642)	**(3,642)**	(3,642)	(2,500)
Capital loan from Department	26	**-**	(700)	**0**	(700)	(1,400)
Total current liabilities		**(36,215)**	(31,542)	**(35,179)**	(31,621)	(37,905)
Net current assets/(liabilities)		**(6,205)**	(7,086)	**(3,256)**	(4,775)	(4,201)
Non-current assets plus/less net current assets/liabilities		**278,637**	249,399	**289,081**	258,950	264,597
Non-current liabilities						
Trade and other payables	24	**(1,093)**	(1,366)	**(1,093)**	(1,366)	(1,639)
Other Liabilities	25	**(386)**	(411)	**(386)**	(411)	(437)
Provisions	29	**(1,384)**	(1,396)	**(1,384)**	(1,396)	(1,399)
Borrowings	26	**(62,841)**	(64,890)	**(62,841)**	(64,890)	(66,762)
Working capital loan from Department	26	**(5,716)**	(9,358)	**(5,716)**	(9,358)	(5,000)
Capital loan from Department	26	**0**	0	**0**	0	(700)
Total non-current liabilities		**(71,420)**	(77,421)	**(71,420)**	(77,421)	(75,937)
Total Assets Employed:		**207,217**	171,978	**217,661**	181,529	188,660
FINANCED BY:						
TAXPAYERS' EQUITY						
Public Dividend Capital		**168,449**	158,594	**168,449**	158,594	158,319
Retained earnings		**(4,681)**	(23,029)	**(5,821)**	(23,029)	(16,504)
Revaluation reserve		**43,449**	36,413	**44,589**	36,413	38,637
Charitable Funds Reserve				**10,444**	9,551	8,208
Total Taxpayers' Equity:		**207,217**	171,978	**217,661**	181,529	188,660

The notes on pages 5 to 41 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves	Public Dividend capital	Retained earnings	Consolidated Revaluation reserve	Charitable Funds Reserve	Total reserves
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2013	**158,594**	**(23,029)**	**36,413**	**171,978**	**158,594**	**(23,029)**	**36,413**	**9,551**	**181,529**
Changes in taxpayers' equity for 2013-14									
Retained surplus/(deficit) for the year	-	5,229	-	**5,229**	-	5,229	-	893	**6,122**
Net gain / (loss) on revaluation of property, plant, equipment			4,141	**4,141**	-	-	-	-	**0**
Transfers between reserves	-	673	(673)	**0**	-	673	(673)	-	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	-	15,772	-	**15,772**	-	15,772	-	-	**15,772**
Reclassification Adjustments									
New PDC Received - Cash	17,953	-	-	**17,953**	17,953	-	-	-	**17,953**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	1,902	-	-	**1,902**	1,902	-	-	-	**1,902**
PDC Repaid In Year	(10,000)			**(10,000)**	(10,000)	-	-	-	**(10,000)**
Other Movements	-	249	- 7	**242**		249		-	**249**
Revaluation and impairment of Charitable fund assets	-	-	-	-	-	-	-		**0**
Charitable Funds Adjustment	-	-	-	-	-	-	-		**0**
Net recognised revenue/(expense) for the year	**9,855**	**21,923**	**3,461**	**35,239**	**9,855**	**21,923**	**(673)**	**893**	**31,998**
Transfers between reserves in respect of modified absorption - PCTs & SHAs	-	(3,575)	3,575	**0**	-	(3,575)	3,575		**0**
Balance at 31 March 2014	**168,449**	**(4,681)**	**43,449**	**207,217**	**168,449**	**(4,681)**	**39,315**	**10,444**	**213,527**
Balance at 1 April 2012	**158,319**	**(16,504)**	**38,637**	**180,452**	**158,319**	**(16,504)**	**38,637**	**8,208**	**188,660**
Changes in taxpayers' equity for the year ended 31 March 2013									
Retained surplus/(deficit) for the year	-	(7,202)	-	(7,202)	-	(7,202)	-	1,343	(5,859)
Impairments and reversals	-	-	(1,524)	(1,524)	-	-	(1,524)	-	(1,524)
Transfers between reserves	-	677	(677)	0	-	677	(677)	-	0
Release of reserves to Statement of Comprehensive Income	-	-	(23)	(23)		-	(23)	-	(23)
New PDC Received	7,495	-	-	7,495	7,495	-	-	-	7,495
PDC Repaid In Year	(7,220)	-	-	(7,220)	(7,220)	-	-	-	(7,220)
Revaluation and impairment of Charitable fund assets	-	-	-	-	-	-	-		0
Charitable Funds Adjustment	-	-	-	-	-	-	-		0
Net recognised revenue/(expense) for the year	**275**	**(6,525)**	**(2,224)**	**(8,474)**	**275**	**(6,525)**	**(2,224)**	**1,343**	**(7,131)**
Balance at 31 March 2013	**158,594**	**(23,029)**	**36,413**	**171,978**	**158,594**	**(23,029)**	**36,413**	**9,551**	**181,529**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2014

				Consolidated	
		2013-14	2012-13	**2013-14**	2012-13
	NOTE	**£'000**	£'000	**£'000**	£'000
Cash Flows from Operating Activities					
Operating Surplus/(Deficit)	SOCI	**22,242**	7,986	**22,242**	7,986
Depreciation and Amortisation	7	**13,831**	12,752	**13,831**	12,752
Impairments and Reversals	7	**(5,670)**	7,226	**(5,670)**	7,226
Donated Assets received credited to revenue but non-cash	5	**(1,269)**	(1,424)	**(1,269)**	(1,424)
Interest Paid	13	**(11,825)**	(10,665)	**(11,825)**	(10,665)
Dividend (Paid)/Refunded		**(4,888)**	(5,807)	**(4,888)**	(5,807)
Release of PFI/deferred credit		**147**	147	**147**	147
(Increase)/Decrease in Inventories	19	**(502)**	(303)	**(502)**	(303)
(Increase)/Decrease in Trade and Other Receivables	20	**(6,312)**	1,342	**(6,312)**	1,342
(Increase)/Decrease in Other Current Assets	21	**1**	(1)	**1**	(1)
Increase/(Decrease) in Trade and Other Payables	24	**435**	(5,751)	**435**	(5,751)
(Increase)/Decrease in Other Current Liabilities	25	**(97)**	45	**(97)**	45
Provisions Utilised	29	**(1,324)**	(241)	**(1,324)**	(241)
Increase/(Decrease) in Provisions	29	**264**	1,339	**264**	1,339
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		-	-	**382**	(277)
Net Cash Inflow/(Outflow) from Operating Activities		**5,033**	6,645	**5,415**	6,368
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest Received	13	**37**	33	**37**	33
(Payments) for Property, Plant and Equipment		**(9,971)**	(14,396)	**(9,971)**	(14,396)
(Payments) for Intangible Assets		**0**	(394)	**0**	(394)
Proceeds of disposal of assets held for sale (PPE)		**0**	2,700	**0**	2,700
NHS Charitable Funds - net cash flows relating to investing activities		-	-	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(9,934)**	(12,057)	**(9,934)**	(12,057)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		**(4,901)**	(5,412)	**(4,519)**	(5,689)
CASH FLOWS FROM FINANCING ACTIVITIES					
Public Dividend Capital Received	SOCITE	**19,855**	7,495	**19,855**	7,495
Public Dividend Capital Repaid	SOCITE	**(10,000)**	(7,220)	**(10,000)**	(7,220)
Loans received from DH - New Revenue Support Loans	26	**0**	8,000	**0**	8,000
Loans repaid to DH - Capital Investment Loans Repayment of Principal	26	**(700)**	(1,400)	**(700)**	(1,400)
Loans repaid to DH - Revenue Support Loans	26	**(3,643)**	(2,500)	**(3,643)**	(2,500)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI	26	**(1,871)**	(1,704)	**(1,871)**	(1,704)
NHS Charitable Funds - net cash flows relating to Financing activities		-	-	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**3,641**	2,671	**3,641**	2,671
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(1,260)**	(2,741)	**(878)**	(3,018)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**2,779**	5,520	**5,321**	8,339
Cash and Cash Equivalents (and Bank Overdraft) at year end		**1,519**	2,779	**4,443**	5,321

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts' Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013-14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts' Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual (FReM). The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCI

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 *Consolidated and Separate Financial Statements* , those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements* , restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Trust Board is the Corporate Trustee of the Buckinghamshire Healthcare NHS Trust Charitable Fund (registered number 1053113), and the valuation of the investment portfolio of that Charity is considered material within the Trust's Accounts. Therefore the Charity is considered to be under common control, with a requirement for consolidation. The main financial statements therefore have consolidated comparators, with further detail provided in Note 39 to the Accounts.

The Accounting Policies adopted by the Charity are disclosed in full in Note 39.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Critical accounting judgements and key sources of estimation uncertainty

Details of the critical judgements and key assumptions concerning the future, and the other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year, are contained within the relevant disclosure notes to these financial statements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- The Trust depreciates the value of its assets over their estimated economic lives. It therefore has to estimate economic lives by taking into account such factors as depreciation and technical obsolescence. The actual life of the asset may be different to that estimated and, therefore, the amount of depreciation charged, and the carrying value of the asset at the date of the Statement of Financial Position, may be different to that which can subsequently be shown as should have been the case.

- In order to calculate the carrying value of the Trust's provisions there are a number of areas which require to be estimated:-

  - The Trust will need to estimate the amount of its liability. In the case of legal claims, for example, it will use the advice of experts but the actual amount of the liability will not be known until the outcome of the litigation

  - The Trust will need to estimate the probability of a liability existing. The outcome of litigation may be uncertain but the Trust will use the advice of its experts on whether it is probable that it will be found liable

  - In the case of pensions and other benefits in the future, an estimate will be made of the length of time that payment will be required to be made, using actuarial mortality tables and discount rates used to estimate the present value of those estimated future payments

  - The Trust will need to estimate the level of recovery of its receivables and make allowances for the expected level of impairment to those receivables. Actual experience may differ from these estimates

1.6 Revenue

Revenue 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 revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Charity's Accounting Policy on recognising income is disclosed in full in Note 39.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, the cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: 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.

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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

The Charity's Accounting Policy on recognising resources expended is shown in Note 39.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Notes to the Accounts - 1. Accounting Policies (Continued)

Valuation

All property, plant and equipment is measured initially at cost, representing the cost 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 used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

The Trust carried out this method of valuation during 2009-10 and the results were included in the Statement of Financial Position at 31st March 2010. The Trust will carry out a full quinquennial valuation on its specialised buildings, and has estimated fair value by commissioning an interim valuation.

Rather than value the individual buildings on a site, the Trust will amalgamate the value of these buildings when considering whether an impairment has occurred (or has been reversed), or when calculating amounts to be taken to the revaluation reserve. This reflects the Modern Equivalent Asset basis applied by the District Valuer which assumes a site made up from a number of blocks will be replaced by one, larger, building.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Notes to the Accounts - 1. Accounting Policies (Continued)

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and, thereafter, to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that, in some areas of AME, inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less costs to sell. Fair value is open market value, including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 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.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

Notes to the Accounts - 1. Accounting Policies (Continued)

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is, instead, treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable, without penalty, on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.18 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (1.80% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 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. The contribution is charged to expenditure. 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 29.

1.20 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 as and when they become due.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.21 Carbon Reduction Commitment Scheme (CRC)

As the NHS body makes emissions, a provision is recognised for the likely cost of untirs under this scheme. The provision is settled on surrender of the allowances.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust holds only loans and receivables. However the Charity holds financial assets (its investments) which are held at fair value. Details on the accounting policy are shown in Note 39.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Loans, Public Dividend Capital and any other interests with government departments are reported at historical costs, less any impairments. Where the receivable is expected to be paid within the next year no discounting of future cash flows takes place.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.24 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.25 Value Added Tax

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.

1.26 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.27 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. Details of third party assets are given in Note 38 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 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).

1.30 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

From 2013-14, the Trust consolidates the results of Buckinghamshire Healthcare NHS Trust Charitable Fund over which it considers it has the power to exercise control in accordance with IAS27 requirements.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project and is revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.32 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14 as they are all subject to consultation. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 27 Separate Financial Statements
IAS 28 Investments in Associates and Joint Ventures
IFRS 9 Financial Instruments
IFRS 10 Consolidated Financial Statements
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IFRS 13 Fair Value Measurement
IPSAS 32 - Service Concession Arrangement

2. Operating Segments

The Trust operates in only one segment namely the provision of healthcare services.

The Trust's main customers were NHS England and Clinical Commissioning Groups (CCGs) which are considered to have been under common control. The Trust's income from NHS England and CCGs for patient care activities during the period was £324,896,000 (2012-13 income from Primary Care Trusts (PCTs) was £313,917,000)

No other single customer accounted for more than 10% of the Trust's income

3. Income generation activities

The Trust has not undertaken any income generating activities whose costs exceed £1million or are otherwise material

4. Revenue from patient care activities	**2013-14 £'000**	2012-13 £'000
NHS Trusts	**1,304**	1,118
NHS England	**69,620**	0
Clinical Commissioning Groups	**255,276**	0
Primary Care Trusts	**0**	313,917
Strategic Health Authorities	**0**	2,287
NHS Foundation Trusts	**111**	0
Department of Health	**0**	4
NHS Other (including Public Health England and Prop Co)	**568**	0
Non-NHS:		
Local Authorities	**5,834**	815
Private patients	**1,104**	971
Overseas patients (non-reciprocal)	**231**	192
Injury costs recovery	**1,920**	1,137
Other	**583**	227
Total Revenue from patient care activities	**336,551**	320,668

Injury costs recovery income is subject to a provision for impairment of receivables for 2013-14 of 12.60% (2012-13 12.60%) to reflect expected rates of collection

5. Other operating revenue	**2013-14 £'000**	2012-13 £'000
Recoveries in respect of employee benefits	**0**	1,778
Education, training and research	**13,042**	10,762
Charitable and other contributions to revenue expenditure -non- NH	**743**	670
Receipt of donations for capital acquisitions - NHS Charity	**1,269**	1,424
Non-patient care services to other bodies	**2,049**	3,583
Income generation	**4,198**	3,990
Other revenue	**1,597**	8,046
Total Other Operating Revenue	**22,898**	30,253
Total operating revenue	**359,449**	350,921

Other revenue includes:-
£1,371,000 (2012-13 £1,450,000) in respect of staff accommodation and other rental services.

In 2012-13 £5,554,000 of Other revenue was from PCTs for non patient care services.

6. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating expenses	**2013-14 £'000**	2012-13 £'000
Trust Chair and Non-executive Directors	**88**	63
Supplies and services - clinical	**55,117**	53,189
Supplies and services - general	**20,011**	20,479
Consultancy services	**1,175**	1,296
Establishment	**4,579**	4,421
Transport	**2,421**	2,406
Premises	**16,242**	15,767
Hospitality*	**19**	0
Insurance*	**231**	0
Legal Fees*	**409**	0
Impairments and Reversals of Receivables	**190**	253
Depreciation	**13,694**	12,691
Amortisation	**137**	61
Impairments and reversals of property, plant and equipment	**(5,670)**	7,226
Audit fees	**146**	146
Clinical negligence	**6,704**	7,650
Education and Training	**1,101**	906
Change in Discount Rate	**53**	56
Other	**4,597**	4,285
Total Operating expenses (excluding employee benefits)	**121,244**	130,895

Other expenditure includes:

Services provided by other organisations £2,219,000 (2012-13 £395,000)
Audit fees other than external audit £226,000 (2012-13 £170,000)
Staff recruitment fees £180,000 (2012-13 £203,000)
Laboratory testing for public health £135,000 (2012-13 £194,000)
* In 2012/13 the expenses on Hospitality, Insurance and Legal Fees were included within 'Other'. These amounts were £6,000, £253,000 and £333,000 respectively.

Employee Benefits	**2013-14 £'000**	2012-13 £'000
Employee benefits excluding Board members	**214,903**	210,899
Board members	**1,060**	1,141
Total Employee Benefits	**215,963**	212,040
Total Operating Expenses	**337,207**	342,935

8 Operating Leases

8.1 Trust as lessee	Land £'000	Buildings £'000	Other £'000	2013-14 Total £'000	2012-13 £'000
Payments recognised as an expense					
Minimum lease payments				**173**	1,996
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**173**	1,996
Payable:					
No later than one year	0	0	163	**163**	1,821
Between one and five years	0	0	130	**130**	266
After five years	0	0	0	**0**	0
Total	**0**	**0**	**293**	**293**	2,087
Total future sublease payments expected to be received:				0	0

Lease payments have reduced in 2013-14 due to the expiry of a property lease at the end of 2012-13.

9 Employee benefits and staff numbers

9.1 Employee benefits

	2013-14 Total £'000	2013-14 Permanently employed £'000	2013-14 Other £'000
Employee Benefits - Gross Expenditure			
Salaries and wages	**183,942**	166,465	17,477
Social security costs	**12,598**	12,598	0
Employer Contributions to NHS BSA - Pensions Division	**20,587**	20,587	0
Other pension costs	**0**	0	0
Termination benefits	**115**	115	0
Total employee benefits	**217,242**	**199,765**	**17,477**
Employee costs capitalised	**1,279**	1,279	0
Gross Employee Benefits excluding capitalised costs	**215,963**	**198,486**	**17,477**

Employee Benefits - Gross Expenditure 2012-13	**Total £'000**	**Permanently employed £'000**	**Other £'000**
Salaries and wages	177,426	161,955	15,471
Social security costs	13,707	13,707	0
Employer Contributions to NHS BSA - Pensions Division	19,968	19,968	0
Other pension costs	0	0	0
Termination benefits	1,948	1,948	0
TOTAL - including capitalised costs	213,049	197,578	15,471
Employee costs capitalised	1,009	1,009	0
Gross Employee Benefits excluding capitalised costs	212,040	196,569	15,471

9.2 Staff Numbers

	2013-14 Total Number	2013-14 Permanently employed Number	2013-14 Other Number	2012-13 Total Number
Average Staff Numbers				
Medical and dental	**600**	567	33	617
Administration and estates	**1,133**	1,095	38	1,118
Healthcare assistants and other support staff	**776**	689	87	889
Nursing, midwifery and health visiting staff	**1,907**	1,689	218	1,808
Scientific, therapeutic and technical staff	**693**	666	27	635
TOTAL	**5,109**	**4,706**	**403**	5,067
Of the above - staff engaged on capital projects	**29**	29	0	32

9.3 Staff Sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	40,744	44,229
Total Staff Years	4,746	4,786
Average working Days Lost	8.58	9.24

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**4**	11
	£000s	£000s
Total additional pensions liabilities accrued in the year	**218**	966

9.4 Exit Packages agreed in 2013-14

Exit package cost band (including any special payment element)	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed	2013-14 Total number of exit packages by cost band	2012-13 *Number of compulsory redundancies	2012-13 *Number of other departures agreed	2012-13 Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	2	0	2	2	13	15
£10,000-£25,000	2	0	2	1	21	22
£25,001-£50,000	1	0	1	2	8	10
£50,001-£100,000	0	0	0	4	1	5
£100,001 - £150,000	0	0	0	0	1	1
£150,001 - £200,000	0	0	0	2	0	2
>£200,000	0	0	0	1	0	1
Total number of exit packages by type (total cost	**5**	**0**	**5**	12	44	56
Total resource cost (£000s)	**83,402**	**0**	**83,402**	843	936	1,780

There were no redundancies or other departures agreed in 2013/14.

In prior years, redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust had agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

Other departure costs were paid in accordance with the Mutually Agreed Resignation Scheme (MARS). No costs in excess of the provisions of the NHS scheme or MARS have been agreed as ex-gratia payments.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

9.5 Exit packages - Other Departures analysis

	2013-14 Agreements	2013-14 Total value of agreements	2012-13 Agreements	2012-13 Total value of agreements
	Number	**£'000**	**Number**	**£'000**
Mutually agreed resignations (MARS) contractual costs	-	-	44	936
Total	-	-	44	936

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

9.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: 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". An outline of these follows:

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 are 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 provided 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.

10 Better Payment Practice Code

Non-NHS Payables	2013-14 Number	2013-14 £'000	2012-13 Number	2012-13 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**62,868**	**156,876**	63,905	172,770
Total Non-NHS Trade Invoices Paid Within Target	**52,264**	**142,281**	52,759	157,426
Percentage of NHS Trade Invoices Paid Within Target	**83.13%**	**90.70%**	82.56%	91.12%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,498**	**52,334**	3,184	**53,160**
Total NHS Trade Invoices Paid Within Target	**1,661**	**47,218**	2,298	**45,467**
Percentage of NHS Trade Invoices Paid Within Target	**66.49%**	**90.22%**	72.17%	85.53%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2 The Late Payment of Commercial Debts (Interest) Act 1998	2013-14 £'000	2012-13 £'000
Amounts included in finance costs from claims made under this legislation	**7**	2
Total	**7**	2

11 Investment Revenue	2013-14 £'000	2012-13 £'000
Interest revenue		
Bank interest	**37**	33
Total investment revenue	**37**	33

12 Other Gains and Losses	2013-14 £'000	2012-13 £'000
Gain (Loss) on disposal of assets held for sale	**0**	894
Total	**0**	894

13 Finance Costs	2013-14 £'000	2012-13 £'000
Interest		
Interest on loans and overdrafts	**170**	210
Interest on obligations under finance leases	**39**	38
Interest on obligations under PFI contracts:		
- main finance cost	**10,672**	9,570
- contingent finance cost	**932**	804
Interest on late payment of commercial debt	**7**	2
Total interest expense	**11,820**	10,624
Provisions - unwinding of discount	**34**	41
Total	**11,854**	10,665

14.1 Property, plant and equipment

2013-14	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	**41,185**	**207,201**	**5,450**	**955**	**41,053**	**246**	**27,143**	**4,011**	**327,244**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**3,780**	**11,454**	**0**	**0**	**863**	**0**	**1,783**	**36**	**17,916**
Transfers under Modified Absorption Accounting - Other Bodies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions of Assets Under Construction				**2,497**					**2,497**
Additions Purchased	0	3,439	0		4,170	0	2,044	301	**9,954**
Additions Donated	0	0	0	0	548	0	721	0	**1,269**
Reclassifications	0	(221)	43	(4)	58	24	(56)	105	**(51)**
Disposals other than for sale	0	(2)	0	0	(228)	(12)	(43)	0	**(285)**
Upward revaluation/positive indexation	145	3,854	142	0	0	0	0	0	**4,141**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**45,110**	**225,725**	**5,635**	**3,448**	**46,464**	**258**	**31,592**	**4,453**	**362,685**
Depreciation									
At 1 April 2013	**0**	**22,510**	**474**	**0**	**29,394**	**246**	**18,400**	**2,656**	**73,680**
Disposals other than for sale	0	0	0		(224)	0	(43)	0	**(267)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	2,482	0	0	0	0	0	0	**2,482**
Reversal of Impairments	0	(7,935)	(217)	0	0	0	0	0	**(8,152)**
Charged During the Year	0	7,931	182		2,145	1	3,226	209	**13,694**
At 31 March 2014	**0**	**24,988**	**439**	**0**	**31,315**	**247**	**21,583**	**2,865**	**81,437**
Net Book Value at 31 March 2014	**45,110**	**200,737**	**5,196**	**3,448**	**15,149**	**11**	**10,009**	**1,588**	**281,248**
Asset financing:									
Owned - Purchased	45,110	110,964	4,427	3,448	10,760	0	9,160	1,518	**185,387**
Owned - Donated	0	12,534	769	0	3,403	11	849	70	**17,636**
Held on finance lease	0	0	0	0	986	0	0	0	**986**
On-SOFP PFI contracts	0	77,239	0	0	0	0	0	0	**77,239**
Total at 31 March 2014	**45,110**	**200,737**	**5,196**	**3,448**	**15,149**	**11**	**10,009**	**1,588**	**281,248**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
At 1 April 2013	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Movements (specify)	18,514	16,160	405	0	1,220	8	0	106	**36,413**
At 31 March 2014	953	6,208	137	0	(240)	0	0	(22)	**7,036**
	19,467	**22,368**	**542**	**0**	**980**	**8**	**0**	**84**	**43,449**

Additions to Assets Under Construction in 2013/14

	£'000
Buildings excl Dwellings	(124)
Plant & Machinery	2,621
Balance as at YTD	**2,497**

14.2 Property, plant and equipment prior-year

2012-13	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation:									
At 1 April 2012	41,185	196,108	5,478	3,234	38,938	246	26,266	3,925	315,380
Additions - Assets Under Construction				945					945
Additions - purchased	0	9,333	0		788	0	825	73	11,019
Additions - donated	0	32	0	0	1,327	0	52	13	1,424
Reclassifications	0	3,224	0	(3,224)	0	0	0	0	0
Impairments	0	(1,496)	(28)	0	0	0	0	0	(1,524)
At 31 March 2013	**41,185**	**207,201**	**5,450**	**955**	**41,053**	**246**	**27,143**	**4,011**	**327,244**
Depreciation									
At 1 April 2012	0	7,980	239	0	26,828	244	16,001	2,471	53,763
Impairments	0	7,177	49	0	0	0	0	0	7,226
Charged During the Year	0	7,353	186		2,566	2	2,399	185	12,691
At 31 March 2013	**0**	**22,510**	**474**	**0**	**29,394**	**246**	**18,400**	**2,656**	**73,680**
Net book value at 31 March 2013	**41,185**	**184,691**	**4,976**	**955**	**11,659**	**0**	**8,743**	**1,355**	**253,564**
Purchased	41,185	172,552	4,234	955	8,294	0	8,601	1,273	237,094
Donated	0	12,139	742	0	3,365	0	142	82	16,470
Total at 31 March 2013	**41,185**	**184,691**	**4,976**	**955**	**11,659**	**0**	**8,743**	**1,355**	**253,564**
Asset financing:									
Owned	41,185	108,839	4,976	955	11,268	0	8,743	1,355	177,321
Held on finance lease	0	0	0	0	391	0	0	0	391
On-SOFP PFI contracts	0	75,852	0	0	0	0	0	0	75,852
Total at 31 March 2013	**41,185**	**184,691**	**4,976**	**955**	**11,659**	**0**	**8,743**	**1,355**	**253,564**

14.3 (cont). Property, plant and equipment

The Trust received donations from, or equipment was funded by, the Buckinghamshire Hospitals Charitable Fund, Scannappeal and Leagues of Friends associated with the Trust's hospital sites.

In 2009/10 the Trust's land and buildings were revalued by the District Valuer, a member of the Royal Institution of Chartered Surveyors (RICS), to arrive at a Modern Equivalent Asset (MEA) valuation.

To arrive at a value, as at an effective date of 31 March 2014, the Trust commissioned an interim valuation, again by the District Valuer, to take account of price movements due to changes in market conditions during financial year 2013/14.

As a result of this interim valuation, the majority of the Trust's land, buildings and dwellings increased in value. This impact has either been reflected through a reversal of a previous impairment, which is taken to the Statement of Comprehensive Income, or as an upwards revaluation, which is taken to the Revaluation Reserve if no previous impairment to that asset took place. This compares with the Trust's buildings and dwellings decreasing in value by 1.4% in 2012-13.

Assets are depreciated on a straight line basis over the following estimated useful economic lives:

	Years
Buildings excluding dwellings	5-85
Dwellings	10-57
Plant and Machinery	5-21
Transport Equipment	7-10
Information Technology	5-12
Furniture and Fittings	7-23
Software Licences	5-12

Each year the Trust is required to reassess the useful economic lives (UELs) of its Property, Plant and Equipment. The reassessment in 2011/12 found that the Trust continued to use the majority of its assets for longer than the useful economic life allocated to them under its existing depreciation estimation methodology. As a result, the Trust extended the life of its non IT equipment by one year and IT equipment by two years. Further work in 2013/14 identified that, although the UELs for most asset groups seemed to be appropriate, assets under Plant and Machinery and Furniture and Fittings headings continued to be used past the lives allocated to them. As a result the UELs were extended for a further year.

15.1 Intangible non-current assets

	Computer Licenses	Total
2013-14		
	£'000	**£'000**
At 1 April 2013	**834**	**834**
Additions - purchased	907	**907**
Reclassifications	51	**51**
At 31 March 2014	**1,792**	**1,792**
Amortisation		
At 1 April 2013	**310**	**310**
Charged during the year	137	**137**
At 31 March 2014	**447**	**447**
Net Book Value at 31 March 2014	**1,345**	**1,345**
Asset Financing: Net book value at 31 March 2014 comprises:		
Purchased	1,335	**1,335**
Donated	10	**10**
Total at 31 March 2014	**1,345**	**1,345**

Revaluation reserve balance for intangible non-current assets

	£'000	£'000
At 1 April 2013	0	**0**
Movements	0	**0**
At 31 March 2014	**0**	**0**

15.2 Intangible non-current assets prior year

	Computer Licenses	Total
2012-13		
	£'000	£'000
Cost or valuation:		
At 1 April 2012	440	440
Additions - purchased	394	394
At 31 March 2013	834	834
Amortisation		
At 1 April 2012	249	249
Charged during the year	61	61
At 31 March 2013	310	310
Net book value at 31 March 2013	524	524
Net book value at 31 March 2013 comprises:		
Purchased	511	511
Donated	13	13
Government Granted		0
Total at 31 March 2013	524	524

The Trust capitalises purchased IT software as an intangible asset. It is held at depreciated replacement cost as a proxy for its fair value

16 Analysis of impairments and reversals recognised in 2013-14	2013-14 Total £'000
Property, Plant and Equipment impairments and reversals taken to SoCI	
Other	2,482
Changes in market price	(8,152)
Total charged to Annually Managed Expenditure	(5,670)
Total Impairments of Property, Plant and Equipment changed to SoCI	(5,670)
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	(5,670)
Overall Total Impairments	(5,670)

Donated and Gov Granted Assets, included above

PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(982)

The Trust incurs capital expenditure on improving the ability of Trust assets to meet service provision requirements, including the usage of different wards and departments. This expenditure, although necessary, may not enhance the overall value of the asset. The Trust would not know this at the commencement of the project. Once the asset is ready to be brought into use the District Valuer is asked to provide a valuation of the new asset. The total of these valuations is compared to the toal amount spent and any difference recognised as either an impairment if negative (as shown under 'Other' above) or as a revaluation gain if positive.

The Trust engaged the District Valuer to undertake an interim valuation of the Trust's land, buildings and dwellings. Where there was a downwards valuation and any revaluation reserve balance was insufficient to cover the movement, the impairment is included within 'Changes in Market Price' above. Where there was an upwards movement, and a previous impairment against that asset had been recognised, this impairment has been reversed through the SOCI before a revaluation reserve balance created. The net figure is shown above. The gross figures are:

	£'000
Reversals of previous impairments	(7,354)
New impairments recognised	341
Total	(7,013)

16.1 Analysis of impairments and reversals recognised in 2013-14

All impairments and reversals have been against Property, Plant and Equipment. There have been none recognised against other categories such as intangible assets

17 Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March 2014 not otherwise included in these financial statements:

	31 March 2014	31 March 2013
	£'000	£'000
Property, plant and equipment	**0**	676
Intangible assets	**0**	255
Total	**0**	931

The Trust had not entered into new commitments for capital projects for 2014/15 and had no outstanding commitments from 2013/14 at the end of the financial year.

18 Intra-Government and other balances	**Current receivables**	**Non-current receivables**	**Current payables**	**Non-current payables**
	£'000	**£'000**	**£'000**	**£'000**
Balances with other Central Government Bodies	12,206	0	8,408	1,093
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	84	0
Balances with NHS Trusts and Foundation Trusts	1,483	0	1,897	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	9,130	2,249	19,598	0
At 31 March 2014	**22,819**	**2,249**	**29,987**	**1,093**
prior period:				
Balances with other Central Government Bodies	6,800	0	7,811	1,366
Balances with Local Authorities	0	0	16	0
Balances with NHS bodies outside the Departmental Group	0	0	61	0
Balances with NHS Trusts and Foundation Trusts	1,418	0	1,319	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	8,288	2,397	14,552	0
At 31 March 2013	**16,506**	**2,397**	**23,759**	**1,366**

19 Inventories	**Drugs**	**Consumables**	**Energy**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Balance at 1 April 2013	**2,375**	**2,625**	**23**	**5,023**
Additions	647	0	44	**691**
Inventories recognised as an expense in the period	0	(189)	0	**(189)**
Balance at 31 March 2014	**3,022**	**2,436**	**67**	**5,525**

20 Trade and other receivables	**Current**		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
NHS receivables - revenue	**12,281**	7,242	**0**	0
NHS prepayments and accrued income	**511**	0	**0**	0
Non-NHS receivables - revenue	**2,695**	3,065	**0**	0
Non-NHS prepayments and accrued income	**6,583**	4,999	**0**	0
Provision for the impairment of receivables	**(454)**	(315)	**0**	0
VAT	**897**	972	**0**	0
Interest receivables	**0**	118	**0**	0
Other receivables	**306**	425	**2,249**	2,397
Total	**22,819**	16,506	**2,249**	2,397
Total current and non current	**25,068**	18,903		

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

20.1 Receivables past their due date but not impaired	**31 March 2014**	31 March 2013
	£'000	£'000
By up to three months	**5,247**	326
By three to six months	**489**	258
By more than six months	**1,361**	899
Total	**7,097**	1,483

20.2 Provision for impairment of receivables	**2013-14**	2012-13
	£'000	£'000
Balance at 1 April 2013	**(315)**	(227)
Amount written off during the year	**51**	165
Amount recovered during the year	**1**	0
(Increase)/decrease in receivables impaired	**(191)**	(253)
Balance at 31 March 2014	**(454)**	**(315)**

21 Other current assets	**31 March 2014**	31 March 2013
	£'000	£'000
Other Assets	**147**	148
Total	**147**	148

22 Cash and Cash Equivalents	**31 March 2014**	31 March 2013
	£'000	£'000
Opening balance	**2,779**	5,520
Net change in year	**(1,260)**	(2,741)
Closing balance	**1,519**	2,779
Made up of		
Cash with Government Banking Service	**1,496**	2,685
Cash in hand	**23**	94
Cash and cash equivalents as in statement of financial position	**1,519**	2,779
Cash and cash equivalents as in statement of cash flows	**1,519**	2,779
Patients' money held by the Trust, not included above	**1**	2

23 Non-current assets held for sale

The Trust had not recognised any assets held for sale in its opening Statement of Financial Position, and did not recognise any assets as such during 2013-14. In 2012-13 the Trust disposed of a piece of land at Stoke mandeville, which was shown in the opening Statement of Financial Position for that year.

24 Trade and other payables	**Current**		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
NHS payables - revenue	**2,807**	4,668	**0**	0
NHS accruals and deferred income	**1,090**	5	**0**	0
Non-NHS payables - revenue	**12,849**	6,474	**0**	0
Non-NHS payables - capital	**5,833**	2,446	**0**	0
Non-NHS accruals and deferred income	**413**	2,899	**0**	0
Social security costs	**1,908**	1,943	**0**	0
VAT	**273**	273	**1,093**	1,366
Tax	**1,439**	2,247	**0**	0
Other	**3,375**	2,804	**0**	0
Total	**29,987**	23,759	**1,093**	1,366
Total payables (current and non-current)	**31,080**	**25,125**		
Included above:				
Outstanding Pension Contributions at the year end	**2,871**	(2,642)		

25 Other liabilities	**Current**		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
PFI/LIFT deferred credit	**25**	26	**386**	411
Other - Private Patient Deposits	**0**	71	**0**	0
Total	**25**	97	**386**	411
Total other liabilities (current and non-current)	**411**	**508**		

26 Borrowings	**Current**		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
Loans from Department of Health	**3,642**	4,342	**5,716**	9,358
PFI liabilities:				
Main liability	**1,952**	1,758	**62,689**	64,641
Finance lease liabilities	**97**	113	**152**	249
Total	**5,691**	**6,213**	**68,557**	**74,248**
Total other liabilities (current and non-current)	**74,248**	**80,461**		

Loans - repayment of principal falling due in:

	31 March 2014		
	DH	**Other**	**Total**
	£'000	**£'000**	**£'000**
0-1 Years	3,642	2,049	**5,691**
1 - 2 Years	1,142	2,309	**3,451**
2 - 5 Years	3,426	6,545	**9,971**
Over 5 Years	1,148	53,987	**55,135**
TOTAL	**9,358**	**64,890**	**74,248**

27 Deferred revenue

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
Opening balance at 1 April 2013	**374**	1,901	**0**	0
Deferred revenue addition	**1,108**	374	**0**	0
Transfer of deferred revenue	**(374)**	(1,901)	**0**	0
Current deferred Income at 31 March 2014	**1,108**	374	**0**	0
Total deferred income (current and non-current)	**1,108**	374		

28 Finance lease obligations as lessee

The Trust has a number of finance leases for equipment including beds and mattresses. The leases are based on the standard NHS lease contract. The terms of the leases vary, depending on the equipment covered, but range from 3 to 15 years, with approximately 5 being the average.

The leases bear no automatic right for the Trust to take possession, to purchase the equipment at a reduced price, or extend the leases at the end of their term, and any extension is negotiated at the time of expiry of the primary lease.

The leases carry an early termination clause, which obliges the Trust to pay the lease payments during the remainder of the term of the lease. The Trust will be responsible for all maintenance and insurance of the leased assets. The Trust would not be able to sub-lease, amend, or otherwise transfer the asset, without the permission of the lease company.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
Within one year	**134**	152	**97**	113
Between one and five years	**231**	365	**152**	249
Less future finance charges	(116)	(155)		
Minimum Lease Payments / Present value of minimum lease payments	**249**	362	**249**	362
Included in:				
Current borrowings			**97**	113
Non-current borrowings			**152**	249
			249	362

29 Provisions

Comprising:

	Total	Early Departure Costs	Legal Claims	Other	Redundancy
	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2013	**2,869**	276	1,360	995	238
Arising During the Year	**437**	5	138	294	0
Utilised During the Year	**(1,324)**	(46)	(53)	(987)	(238)
Reversed Unused	**(173)**	(9)	(155)	(9)	0
Unwinding of Discount	**34**	6	28	0	0
Change in Discount Rate	**53**	4	49	0	0
Balance at 31 March 2014	**1,896**	**236**	**1,367**	**293**	**0**
Expected Timing of Cash Flows:					
No Later than One Year	**512**	37	182	293	0
Later than One Year and not later than Five Years	**528**	128	400	0	0
Later than Five Years	**856**	71	785	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£'000
As at 31 March 2014	47,558
As at 31 March 2013	45,619

The uncertainty of timing or amounts relating to the classes of provision above are:

Pensions - uncertainty in respect of the length of time payable and therefore for the obligation for future payments.

Legal Claims - For Employer Liability claims there are uncertainties relating to the likelihood of the Trust being held liable and the amount of any awa

For Injury benefit claims the uncertainty relates to the length of time over which these may be payable.

Other Provisions relate to carbon trading assessments, where there is an uncertainty of amount. In the previous year Other Provisions also included potential Legal fees with an uncertainty around amount and Employment Tribunal claims with uncertainty relating to likelihood and amount.

30 Contingencies

	31 March 2014	31 March 2013
	£'000	£'000
Contingent liabilities		
Other - Legal Claims	**(36)**	(40)
Net Value of Contingent Liabilities	**(36)**	(40)

Contingent liabilities relate to the outstanding Employer Liability claims and represent the difference between the maximum likely cost to the Trust and the value included under provisions. They have been calculated based on information provided by the NHS Litigation Authority. It is anticipated that all of the claims will be resolved during 2014/2015.

31 PFI - Additional information

The Trust has two Private Finance Initiative (PFI) contracts known as the 'South Bucks' contract for the buildings at Wycombe and Amersham Hospitals and the 'Stoke Mandeville' contract for the building at Stoke Mandeville.

The South Bucks scheme was for the provision of a new building at Wycombe Hospital, and an almost complete rebuild of Amersham Hospital. The contract was signed in December 1997 and the new buildings were fully operational in November 2000. The contract length is 63 years and the Trust has an option to break the contract at 33 years, 43 years and every 5 years after that.

The Trust provided two smaller sites to the PFI partner in exchange for a reduced unitary payment during the contract term and the value of this exchange is accounted for as deferred expenditure. As part of this contract, the facilities management services at Wycombe and Amersham will be provided by the PFI partner over the lifetime of the contract.

The Stoke Mandeville scheme was for the re-provision of 11 wards (238 beds), a new entrance and restaurant and a new burns unit on the Stoke Mandeville site. The contract was signed in May 2004 and the new buildings became fully operational in August 2006. The contract was for 32 years from the date of signing.

As part of the contract terms, the PFI partner will be responsible for the provision of facilities management during the lifetime of the contract and will receive a guaranteed amount of income from catering and provision of car parking.

In both cases the Trust retains the ownership of the land. During the period of the contract the Trust is obliged to retain buildings, although it can specify what services are provided on each site.

Under IFRIC 12 the Trust treats the assets (buildings) resulting from these contracts as its own and their value is included within the Statement of Financial Position (totalling £75,852,000 for both sites). It also includes a liability for the payment that is required to be made to the PFI partners (totalling £66,399,000).

The Unitary Payment paid to the PFI partners is accounted for partly as costs relating to the supply of the facilities management services under General Supplies and Services and partly as finance costs relating to the lease of the buildings.

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON SOFP PFI	**2013-14 £'000**	2012-13 £'000
Service element of on SOFP PFI charged to operating expenses in year	**17,542**	17,905
Total	17,542	17,905
Payments committed to in respect of the service element of on SOFP PFI		
No Later than One Year	**17,981**	18,353
Later than One Year, No Later than Five Years	**71,924**	73,410
Later than Five Years	**255,256**	270,862
Total	**345,161**	362,625

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-14 £'000**	2012-13 £'000
No Later than One Year	**11,930**	11,598
Later than One Year, No Later than Five Years	**47,874**	46,663
Later than Five Years	**252,968**	252,928
Subtotal	**312,772**	311,189
Less: Interest Element	**(248,130)**	(244,790)
Total	**64,642**	66,399

32 Impact of IFRS treatment - current year	**2013-14 £'000**	2012-13 £'000
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**1,162**	1,023
Interest Expense	**4,609**	4,512
Impairment charge - AME	**(2,794)**	537
Other Expenditure	**10,515**	9,614
Impact on PDC dividend payable	**(30)**	(61)
Total IFRS Expenditure (IFRIC12)	**13,462**	**15,625**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(15,532)**	(14,472)
Net IFRS change (IFRIC12)	**(2,070)**	**1,153**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
UK GAAP capital expenditure 2013-14 (Reversionary Interest)	**482**	466

33 Financial Instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

33.2 Financial Assets	**Loans and receivables**	**Total**
	£'000	**£'000**
Receivables - NHS	12,792	**12,792**
Receivables - non-NHS	7,680	**7,680**
Cash at bank and in hand	1,519	**1,519**
Other financial assets	41	**41**
Total at 31 March 2014	**22,032**	**22,032**
Receivables - NHS	6,801	6,801
Receivables - non-NHS	7,061	7,061
Cash at bank and in hand	2,779	2,779
Other financial assets	41	41
Total at 31 March 2013	16,682	16,682

33.3 Financial Liabilities	**Other**
	£'000
NHS payables	2,807
Non-NHS payables	22,057
Other borrowings	9,358
PFI & finance lease obligations	64,890
Other financial liabilities	0
Total at 31 March 2014	**99,112**
NHS payables	9,031
Non-NHS payables	9,893
Other borrowings	13,700
PFI & finance lease obligations	66,761
Other financial liabilities	71
Total at 31 March 2013	99,456

34 Events after the end of the reporting period

There have been no such events that require disclosure or amendment to these financial statements.

35 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Buckinghamshire Healthcare NHS Trust.

The Department of Health is regarded as a related party. During the year Buckinghamshire Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:-

Chiltern Clinical Commissioning Group
Aylesbury Vale Clinical Commissioning Group
Herts Valleys Clinical Commissioning Group
Bedfordshire Clinical Commissioning Group
Wessex Area Team
Thames Valley Local Area Team
NHS Litigation Authority
Health Education England

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HMRC in respect of taxes and national insurance contributions, and Aylesbury Vale District Council and Wycombe District Council both in respect of rates.

The Trust has also received revenue and capital payments from a number of charitable funds including Buckinghamshire Hospitals Charitable Fund, certain of the trustees for which are also members of the Trust board. The summary financial statements of the Funds Held on Trust are consolidated in these accounts.

36 Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £	Total Number of Cases
Losses	51,416	70
Special payments	65,599	47
Total losses and special payments	117,015	117

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £	Total Number of Cases
Losses	186,071	88
Special payments	10,035	27
Total losses and special payments	196,106	115

37. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

37.1 Breakeven performance	2005-06 £'000	2006-07 £'000	2007-08 £'000	2008-09 £'000	2009-10 £'000	2010-11 £'000	2011-12 £'000	2012-13 £'000	2013-14 £'000
Turnover	228,086	252,488	275,643	280,557	294,906	345,367	340,397	350,921	**359,449**
Retained surplus/(deficit) for the year	28	43	1,729	(2,750)	(28,090)	2,654	4,338	(7,202)	**5,229**
Adjustment for:									
Timing/non-cash impacting distortions:									
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0								
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0							
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0						
Adjustments for Impairments				0	28,236	(2,407)	(2,751)	7,226	**(5,670)**
Adjustments for impact of policy change re donated/government grants assets							734	(341)	**37**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					0	779	527	616	**724**
Adsorption Accounting Adjustment								0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	**0**	**0**
Break-even in-year position	**28**	**43**	**1,729**	**(2,750)**	**146**	**1,026**	**2,848**	**299**	**320**
Break-even cumulative position	**(2,977)**	**(2,934)**	**(1,205)**	**(3,955)**	**(3,809)**	**(2,783)**	**65**	**364**	**684**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
Materiality test (I.e. is it equal to or less than 0.5%):									
Break-even in-year position as a percentage of turnover	0.01	0.02	0.63	-0.98	0.05	0.30	0.84	0.09	0.09
Break-even cumulative position as a percentage of turnover	-1.31	-1.16	-0.44	-1.41	-1.29	-0.81	0.02	0.10	0.19

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

37.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

37.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

		2013-14	2012-13
	£'000	**£'000**	£'000
External financing limit (EFL)		**5,389**	8,690
Cash flow financing	**4,901**		5,412
Unwinding of Discount Adjustment	**34**		0
Finance leases taken out in the year	**0**		0
Other capital receipts	**0**		0
External financing requirement		**4,935**	5,412
Under/(Over) Spend against EFL		**454**	3,278

37.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-14	2012-13
	£'000	£'000
Gross capital expenditure	**14,654**	13,782
Less: book value of assets disposed of	**0**	(1,800)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(1,269)**	(1,424)
Charge against the capital resource limit	**13,385**	10,558
Capital resource limit	**13,424**	10,835
(Over)/underspend against the capital resource limit	**39**	277

38 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2014	31 March 2013
	£'000	£'000
Third party assets held by the Trust	**1**	2

39 Consolidation of the Associated Charity

As outlined in Note 1.4 to the Accounts, where the Trust has an associated Charity under common control, it is required to produce consolidated financial statements. The information below outlines the consolidation process, the Charity's results and amounts consolidated.

The Charity shares the same financial year as the Trust, but is not subject to the NHS reporting timetable. Therefore at the point of preparation and audit of these Accounts, the Charity's results had not been audited and may be subject to change.

In addition the Charity is not required to report under International Financial Reporting Standards. It is required to comply with UK Generally Accepted Accounting Practice and there will be differences in Accounting Standards and Policies between the two. As a part of the consolidation exercise, areas which may be affected by the divergence in Accounting Standards, particularly around valuation of assets and liabilities, were assessed, and there was no resultant requirement to restate the Charity's results.

Where there have been transactions between the Trust and the Charity, the impact of these transactions needs to be removed to avoid 'double-counting'. For example, where the Charity has expenditure with the Trust, which the Trust has recorded as income, both entries need to be removed to avoid over-inflating the results. However, where the Charity has provided funding against Trust expenditure which has been recharged, the expenditure will only be shown in the Charity's figures so has been consolidated.

There will be specific Accounting Policies which may not be applicable to the Trust, but which may affect the recognition and valuation of financial transactions within the Charity's Accounts. In particular:

a. All incoming resources are met in full as soon as three factors are met:
   Entitlement - when a particular resource is receivable or the Charity becomes legally entitled,
   Certainty - when there is reasonable certainty that the incoming resource will be received, and
   Measurement - when the monetary value can be measured with sufficient reliability

   This is of relevance when considered legacies. When confirmation has been received from representatives of the estate that payment of the legacy will be made or property transferred and, once all conditions attached to the legacy have been fulfilled, the incoming resource will be recognised.

b. Expenditure is recognised when a liability is incurred. Grant commitments are recognised when a constructive obligation arised that results in payment being unavoidable. Liability for unconditional grants is recognised when approval is given by the Trustee. Where the Trustee pledges support for the cost of an ongoing project the costs are accrued within the Charity as the costs are incurred on the project.

c. Investment fixed assets are shown at market value.
   •Quoted stocks and shares are included in the Statement of Financial Position at mid-market price, excluding
   •Other investment fixed assets are included at the Trustee's best estimate of market value.

   All gains and losses are taken to the Income Statement as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or cost at date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or cost at date of purchase if later).

   Due to the exposure to market value of investments the Charity's, and therefore the Group's, exposure to risk with regard to financial assets is different to that of the Trust. Market values of investments can go down as well as up.

39.1 Group Statement of Comprehensive Income

	2013-14				2012-13			
	Trust Only £'000	Charity Only £'000	Inter - Company** £'000	**Consolidated £'000**	Trust Only £'000	Charity Only £'000	Inter - Company** £'000	**Consolidated £'000**
Gross employee benefits	(215,963)	0	0	**(215,963)**	(212,040)	0	0	**(212,040)**
Other operating costs	(121,244)	(782)	268	**(122,294)**	(130,895)	(2,307)	1,108	**(134,310)**
Revenue from patient care activities	336,551	0	0	**336,551**	320,668	0	0	**320,668**
Other Operating revenue	22,898	1,198	(268)	**24,364**	30,253	2,660	(1,108)	**34,021**
Operating surplus/(deficit)	22,242	416	0	**22,658**	7,986	353	0	**8,339**
Investment revenue	37	222	0	**259**	33	194	0	**227**
Other gains and (losses)	0	0	0	**0**	894	0	0	**894**
Finance costs	(11,854)	0	0	**(11,854)**	(10,665)	0	0	**(10,665)**
Surplus/(deficit) for the financial year	10,425	638	0	**11,063**	(1,752)	547	0	**(1,205)**
Public dividend capital dividends payable	(5,196)	0	0	**(5,196)**	(5,450)	0	0	**(5,450)**
Retained surplus/(deficit) for the year	5,229	638	0	**5,867**	(7,202)	547	0	**(6,655)**

Other Comprehensive Income	2013-14				2012-13			
	Trust Only £'000	Charity Only £'000	Inter - Company £'000	**Consolidated £'000**	Trust Only £'000	Charity Only £'000	Inter - Company £'000	**Consolidated £'000**
Net gain/(loss) on revaluation of property, plant &	4,141	0	0	**4,141**	(1,524)	0	0	**(1,524)**
Net gain/(loss) on revaluation of financial assets	0	255	0	**255**	0	796	0	**796**
Total Comprehensive Income for the year*	9,370	893	0	**10,263**	(8,726)	1,343	0	**(7,383)**

*Retained surplus/(deficit) plus Other Comprehensive Income

** Inter-Company transactions relate to the purchase of assets donated to the Trust and the governance costs of the Charity. These transactions are shown as expenditure in one set of Accounts and revenue in the other. For this reason the impact must be removed.

39.2 Group Statement of Financial Position

	2013-14				2012-13				2011-12			
	Trust Only £'000	Charity Only £'000	Inter - Company* £'000	**Consolidated £000s**	Trust Only £'000	Charity Only £'000	Inter - Company* £'000	**Consolidated £'000**	Trust Only £'000	Charity Only £'000	Inter - Company* £'000	**Consolidated £'000**
Non-current assets:												
Property, plant and equipment	281,248	0	0	281,248	253,564	0	0	253,564	261,617	0	0	261,617
Intangible assets	1,345	0	0	1,345	524	0	0	524	191	0	0	191
Other Investments - Charitable		7,495	0	7,495		7,240	0	7,240		4,445	0	4,445
Trade and other receivables	2,249	0	0	2,249	2,397	0	0	2,397	2,545	0	0	2,545
Total non-current assets	284,842	7,495	0	292,337	256,485	7,240	0	263,725	264,353	4,445	0	268,798
Current assets:												
Inventories	5,525	3	0	5,528	5,023	5	0	5,028	4,720	2	0	4,722
Trade and other receivables	22,819	282	206	22,895	16,506	334	491	16,349	17,582	1,302	188	18,696
Other current assets	147	0	0	147	148	0	0	148	147	0	0	147
Cash and cash equivalents	1,519	2,924	0	4,443	2,779	2,542	0	5,321	5,520	2,819	0	8,339
Total current assets	30,010	3,209	206	33,013	24,456	2,881	491	26,846	27,969	4,123	188	31,904
Non-current assets held for sale	0				0				1,800			
Total current assets	30,010	3,209	206	33,013	24,456	2,881	491	26,846	29,769	4,123	188	31,904
Total assets	314,852	10,704	206	325,350	280,941	10,121	491	290,571	294,122	8,568	188	300,702
Current liabilities												
Trade and other payables	(29,987)	(260)	(206)	(30,041)	(23,759)	(570)	(491)	(23,838)	(31,869)	(360)	(188)	(32,041)
Other liabilities	(25)	0	0	(25)	(97)	0	0	(97)	(26)	0	0	(26)
Provisions	(512)	0	0	(512)	(1,473)	0	0	(1,473)	(234)	0	0	(234)
Borrowings	(2,049)	0	0	(2,049)	(1,871)	0	0	(1,871)	(1,704)	0	0	(1,704)
Working capital loan from Department	(3,642)	0	0	(3,642)	(3,642)	0	0	(3,642)	(2,500)	0	0	(2,500)
Capital loan from Department	0	0	0	0	(700)	0	0	(700)	(1,400)	0	0	(1,400)
Total current liabilities	(36,215)	(260)	(206)	(36,269)	(31,542)	(570)	(491)	(31,621)	(37,733)	(360)	(188)	(37,905)
Net current assets/(liabilities)	(6,205)	2,949	0	(3,256)	(7,086)	2,311	0	(4,775)	(7,964)	3,763	0	(6,001)
Non-current assets plus/less net current asse	278,637	10,444	0	289,081	249,399	9,551	0	258,950	256,389	8,208	0	262,797
Non-current liabilities												
Trade and other payables	(1,093)	0	0	(1,093)	(1,366)	0	0	(1,366)	(1,639)	0	0	(1,639)
Other Liabilities	(386)	0	0	(386)	(411)	0	0	(411)	(437)	0	0	(437)
Provisions	(1,384)	0	0	(1,384)	(1,396)	0	0	(1,396)	(1,399)	0	0	(1,399)
Borrowings	(62,841)	0	0	(62,841)	(64,890)	0	0	(64,890)	(66,762)	0	0	(66,762)
Working capital loan from Department	(5,716)	0	0	(5,716)	(9,358)	0	0	(9,358)	(5,000)	0	0	(5,000)
Capital loan from Department	0	0	0	0	0	0	0	0	(700)	0	0	(700)
Total non-current liabilities	(71,420)	0	0	(71,420)	(77,421)	0	0	(77,421)	(75,937)	0	0	(75,937)
Total Assets Employed:	207,217	10,444	0	217,661	171,978	9,551	0	181,529	180,452	8,208	0	186,860
FINANCED BY:												
TAXPAYERS' EQUITY												
Public Dividend Capital	168,449		0	168,449	158,594		0	158,594	158,319		0	158,319
Retained earnings	(4,681)		0	(4,681)	(23,029)		0	(23,029)	(16,504)		0	(16,504)
Revaluation reserve	43,449		0	43,449	36,413		0	36,413	38,637		0	38,637
Charitable Funds Reserve		10,444	0	10,444		9,551	0	9,551	0	8,208	0	8,208
Total Taxpayers' Equity:	207,217	10,444	0	217,661	171,978	9,551	0	181,529	180,452	8,208	0	188,660

*Inter-company transactions relate to Receivables and Payables between the Trust and the Charity that had not been settled by the year end. They are not more than 30 days old.

13. Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

nb: sign and date in any colour ink except black

.....Date.....Chief Executive

.....Date.....Finance Director

14. Statement of chief executive's responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

nb: sign and date in any colour ink except black

Signed.....Chief Executive

Date.....

15. Annual governance statement

Insert name of organisation: Buckinghamshire Healthcare NHS Trust

Organisation Code: RXQ

GOVERNANCE STATEMENT

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review reflects a number of informed views, of which there are three key elements. Firstly, The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Head of Internal Audit has provided the following opinion:

Based on the work undertaken in 2013/2014, 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 were identified that put the achievement of particular objectives at risk. The key issues identified within our initial audit plan were:

- Our **Data Quality – Data Capture, Validation and Reporting for Dementia Screening** review resulted in a Red Assurance Opinion and weaknesses were identified in respect of both the design and application of the control framework. This could have impacted on the Trust's ability to achieve the CQUIN target of c£350k.

- Our **Access Targets – 18 Weeks Referral to Treatment (RTT)** resulted in a red opinion with weaknesses being identified in terms of the design and application of the control framework. In all cases management have agreed actions to rectify the weaknesses identified. There was a risk that data is not correctly captured on the CRS system resulting in ineffective monitoring and reporting of performance targets due to poor data quality.

- Our review in respect of **Care Quality Commission – Evidence Gathering, Documentation and Demonstrating Remedial Action Taken Based on Review of Evidence** was given a Red Opinion with weaknesses identified in terms of the design and application of the control framework. It is important to emphasise that our opinion did not imply or suggest that the actual compliance with the care quality standards was not at the expected standard of the CQC. Our follow up review demonstrated that all high categorised recommendations had either been implemented or deemed no longer to be high as sufficient progress had been made with their implementation mitigating the risks identified in our initial report.

Secondly, executive directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance that the controls are in place.

Thirdly, the Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- The key findings and action plan arising from the risk summit held following the *"Review*

into the Quality of Care & Treatment provided by 14 Hospitals Trusts in England"

- The Board Governance Review report and recommendations undertaken by KPMG
- The self assessment undertaken by the Trust against Care Quality Commission regulations and reports emerging from CQC visits
- External reviews from other sources such as the Deanery, clinical networks, Clinical Pathology Accreditation, Joint Advisory Group on GI Endoscopy and the Health and Adult Social Care Select Committee for Buckinghamshire County Council
- The annual report of the Trust's external auditors and regular reports from the Trust's internal auditors and the annual Head of Internal Audit Opinion.
- A comprehensive programme of clinical audit
- Internal monitoring arrangements such as the Healthcare Governance Report, quality report, financial, workforce and operational performance reports
- Trust Development Authority monitoring and other benchmarking.

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, Audit Committee and Healthcare Governance Committee, and the Quality Committee which replaced it. A system of continuous improvement is in place with in-depth focussed work triggered by identification of risks through self-assessment and self-monitoring.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by the following:

- The work of the Trust Board with its underpinning governance structure and processes. This has been substantially strengthened in 2013/14. This is described in more detail later in this statement.
- Appraisal and performance management of the work of the executive directors, general and clinical managers.
- The Internal Audit work plan based on risks identified through the assurance framework and risk register.
- External Audit reports

The Board has monitored progress against the top risks facing the Trust and assured itself that the strategic intent of the Trust appropriately addresses the risks facing the Trust and the continual improvement of the totality of its business.

The Audit Committee has sought and received assurance from the Trust's Internal and External Auditors from the agreed audit programmes which have been developed with reference to gaps in assurance as identified by the Board Assurance Framework.

The Healthcare Governance/Quality Committee has sought and received assurance on healthcare governance processes in the organisation through the delivery of a clinical audit plan. This plan includes the following (not exhaustive):

- National Clinical Audit Projects reported in Quality Accounts
- CQUINS, Schedule 3 and other commissioner priorities
- Infection Control Monitoring
- Cancer Peer Review Audit
- Audits resulting from Serious Incidents
- Doctor Foster alerts or significant variance in key clinical indicators
- Audits associated with the Quality Improvement Strategy and Quality Improvement Plan
- Audit need identified by Risk Monitoring Group/Healthcare Governance Committee

SCOPE OF RESPONSIBILITY

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports delivery of the policies, aims and objectives of Buckinghamshire Healthcare NHS Trust. I also have responsibility for safeguarding the public funds and assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

I am accountable to the Chair of the Trust and the Chief Executive of the NHS Trust Development Authority. I am performance managed through appraisal undertaken by the Chair of the Trust Board.

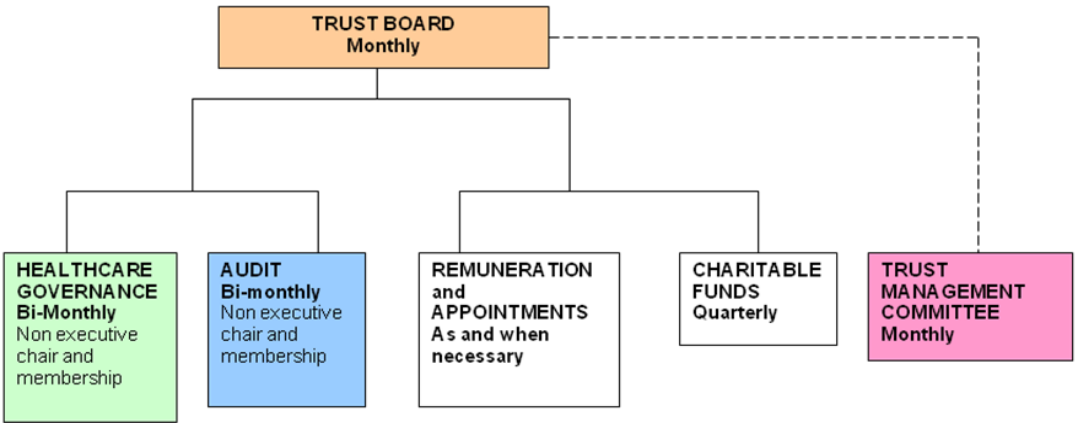
In addition, the NHS Trust Development Authority Board and Executive Team have met regularly with me and my directors to formally review our performance in delivering the organisation's objectives through the monthly Integrated Delivery Meetings. In particular, we have been reviewed this year on our delivery of the agreed action plan arising from the risk summit held following the *"Review into the Quality of Care & Treatment provided by 14 Hospitals Trusts in England".* I work with partners across the health and social care economy through the Health and Wellbeing Board. In particular there are strong relationships with HealthWatch and local Clinical Commissioning Groups - Chiltern, and Aylesbury Vale. This working partnership includes performance and contract reviews, regular meetings with the executive team, and with other leaders in Buckinghamshire at the whole system transformation Board.

THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

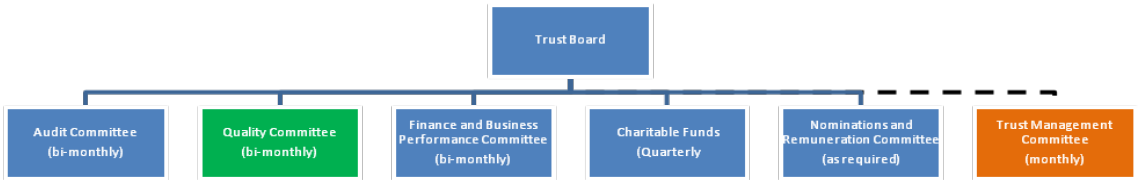
The role of the Board and the Board committees is critical to setting the strategic direction and monitoring the delivery of the organisation's objectives. An integrated governance framework and processes are in place across the organisation. This is to ensure that information flows clearly to the Board providing assurance where possible and highlighting risk identified through gaps in control or gaps in assurance. This supports strategic decision making by the Board which in turn flows back through the organisation.

These arrangements has been substantially reviewed and amended in 2013/14 as a result of the Board Governance Review undertaken by KPMG. The diagram below illustrates the top level governance structure, both before and after the review. The Board working arrangements, including composition of the Executive and Non-Executive membership, the committee structure and membership and Board development plan are in line with the Code of Governance expected of NHS Foundation Trusts.

Board of Directors Committee Structure



Board of Directors Revised Committee Structure



The Board has responsibility for setting the overall direction, agreeing the Trust's principal objectives, assessing and managing strategic risks to the delivery of those objectives and monitoring progress through regular performance monitoring reports

The Board has delegated scrutiny of assurance processes, finance and information to three of its sub-committees, the Audit, Finance and Business Performance and Quality Committees. The committees work together to deliver an integrated approach to governance. All three of these committees have a non-executive chair and membership with a significant common membership across the three committees. Each has terms of reference, which have been reviewed and amended in 2013/14, and an annual work plan approved by the Board.

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective internal control and risk management process across the whole of the Trust's activities that supports the achievement of the Trust's objectives, and monitors:

- the integrity of the financial statements of the Trust;
- the independent auditors' qualifications, independence and performance;
- the performance of the Trust's Internal Audit function and Local Counter Fraud provision;
- Compliance by the Trust with legal and regulatory requirements.

The Quality Committee provides the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. It assures the Board directly and through consultation with the Audit Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health services. It also assures the Board that where risks and issues that may jeopardise the Trust's ability to deliver excellent quality healthcare are being managed in a controlled and timely way.

The purpose of the Finance and Business Performance Committee is to provide the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. On behalf of the Trust Board, the Finance and Business Performance Committee will oversee all aspects of the financial arrangements of the Trust. It will provide the Trust Board with assurance that the financial issues of the Trust are being appropriately addressed, and will provide the Board with information and advice on key issues. The Committee also has oversight of the Trust's performance management framework and will, as required, focus on specific issues where the Trust's performance is deteriorating or there are issues of concern.

The Trust Management Committee provides a forum for making major operational decisions in support of my role of Chief Executive. It is the most senior management committee of the Trust. The purpose of the Committee is to assist me in the performance of my duties including:

- The development and implementation of strategy, operational plans, policies, procedures and budgets;
- The monitoring of operating and financial performance;
- The assessment and control of risk identified through the assurance framework
- The prioritisation and allocation of resources

The Risk Monitoring Group, reports to the Trust Management Committee escalating any urgent risks and issues.

Chaired by the Chair of the Trust with a non-executive membership plus the Chief Executive the Nominations and Remuneration Committee oversees:

- the formal, rigorous and transparent procedures in place for the appointment of executive directors to the Board;
- the remuneration policy and performance management framework.
- restructuring and redundancy

The Charitable Funds Committee has a non-executive membership plus the Director of Finance. The overall purpose of the Committee is to assist the Board in the performance of

their duties through providing assurance the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales. The Committee approves charitable funds expenditure in accordance with standing orders and standing financial instructions as well as approving investment policy and monitoring investments on a regular basis.

Each clinical division is held accountable for corporate and clinical governance through an accountability framework which includes responsibility for annual Business & Service Planning; Governance (management of risk, patient safety and learning feedback, quality); Diversity & Equality; Workforce management; Financial Management; Physical Environment Management; Access and Operational Performance targets; Research and Development; and Information Management.

The Board recognises that Board skills, knowledge, experience, ways of working and Board dynamics are critical in ensuring a capable and competent Board to lead the organisation and its people into a successful future. The Board underwent significant changes in personnel, both at Executive and non-executive level, during 2013/14. The Board also undertook very significant amounts of training during the year

The Board has developed a two year Board Development Plan for 2013/14 and 2014/15 following a self review. This self review comprised an externally facilitated 360 degree review for each board member and a stakeholder review including both internal and external stakeholders. Implementation of the Board Development Plan has been influenced by the action plans arising from the Risk summit and the KPMG Governance Review, which is grouped under header as *"Every Patient Counts"*

Progress against goals for Board development in 2013/14 are as follows:

Goal	**Progress**
Progressing Every Patient Counts Action Plan	An action plan was developed and monitored as part of the Board Development Plan. All actions were signed off into business as usual by January 2014. Progress was confirmed at an NHS England risk summit in December 2013.
Salford Royal Foundation NHS Trust Peer Support	Sir David Dalton, CEO Salford Royal Foundation NHS Trust facilitated a Board Seminar on staff engagement on 21 August 2013.
Progressing Speaking Out Investigation	Dr Androulla Johnstone, an external consultant, led the Speaking Out Investigation and reported to the Board
Recruiting a new substantive Chair	New Chair with considerable experience in NHS Chair roles commenced in March 2014, following retirement of the Chair on 31 December 2013

A review of attendance by Board members at Board meetings, seminars and sub-committees shows great commitment from all Board members, good attendance and no issues of quoracy

The Audit Committee and Healthcare Governance / Quality Committee provided reports to each public Board meeting. Key items of note from these reports are as follows:

Audit Committee

- The importance of timely response to internal audits by management.
- The cash liquidity position had been discussed and concern noted.
- Further assurance required on the process for identifying and managing drivers on length of stay
- The follow up and review of red and red/amber audit reports
- Risk to quality of care from over-reliance on agency staff

Healthcare Governance and Quality Committee

- Highlighting risks from the Divisional Risk Registers
- The operating theatres Never Events Action Plan
- Key governance issues following from Quality & Mortality Review
- Care Quality Commission Reports following unannounced inspections
- Quality Assurance of the Cost Improvement Programme (CIP)

Finance and Business Performance Committee

- Agreed Terms of Reference
- Establishing the role of the Committee in relation to the Audit Committee
- Reviewed outline Business Plan
- Financial performance

The Board is compliant with all aspects of the UK Corporate Governance Code (Financial Reporting Council September 2012) which apply to an NHS Trust.

Risk assessment

The risk management process is led by the Trust Board which is responsible for the overall governance of the Trust. The Board reviews the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Trust Board has led the process with the approval of a Risk Management Strategy and Policy, which ensures that the Trust approaches the control of risk in a strategic and organised manner. The strategy describes the corporate and individual accountability for managing risk, the risk management process, the approach to training and how the success of the strategy will be monitored. Both the Risk Management Strategy and Policy have been reviewed and updated during 2013/14.

Each executive director has leadership of a specific area of risk in addition to their corporate Board responsibilities. At the divisional level, risk management is led by the Divisional Chairs, Assistant Chief Operating Officers, Associate Chief Nurses, together with senior managers.

Risk management training and awareness is included in the mandatory corporate induction programme and further specialist courses have been delivered to staff throughout the year, including training for senior managers and directors. In addition a series of Risk Management Workshops, led by KPMG have, been held to strengthen awareness of risk management at Divisional level. In excess of 60 senior managers and clinicians attended these workshops. Guidance on risk management is also provided to staff by specialist advisers that include:

- The Director of Infection Prevention and Control, and the Control of Infection Team
- The Head of Occupational Health
- The Health and Safety Adviser
- The Fire Safety Advisers

- The Radiological Protection Adviser
- The Chief Pharmacist
- The Child Protection Designated Nurse and Designated Doctor
- The Human Tissue Act Designated Individuals

The Board is committed to a culture of continual learning and quality improvement. The Board and its Committees receive feedback from audits, inspections and incident reporting. Sharing of good practice and continual learning relating to clinical risk is ensured through the Risk Monitoring Group. This group is the forum for monitoring of clinical risk issues identified by the Divisions and identified risk sub-groups. It provides assurance to the Healthcare Governance Committee that clinical risks are being appropriately reported and managed, and facilitates the dissemination of learning across the organisation.

Risks identified in 2013/14

A range of risks were identified in 2013/14 and were reported to the Board through the Board Assurance Framework and the associated *Heatmap*, which highlights increases and decreases in the scale of the risk. Newly identified risks facing the organisation during the year were as follows:

- Delivery of the emergency access target (4 hour). This has the potential to impact on quality for patients on the urgent care pathway The Trust has formed a Reforming Urgent Care Programme Board chaired by Chief Operating Officer , put in action plans against seven work streams and is working with the national Emergency Care Intensive Support Team

- Meeting the national 18 week waiting times/quality service standards, with a negative impact on patient experience. - The Trust has set up a Reforming Elective Care Programme Board chaired by Chief Operating Officer with action plans against key work streams and is working with the national Elective Intensive Support Team support

- Insufficient Interventional Radiology provision in-hours can result in less than ideal patient care – steps have been taken to ensure radiologists doing extra sessions where possible. Monitoring of waiting lists has been stepped up, and a review of clinical conditions of patients to establish if other treatment is possible has been undertaken.
- Outpatient booking is inadequate. Out of date telephone system and staff shortages result in inefficiency in booking/re-arranging outpatient appointments, increased levels of non-attendance wasted outpatient slots, poor service to GPs, poor patient experience and increased patient complaints – telephone system issued addressed and waiting times/lists closely monitored
- Quality of care and treatment may be variable if 7 day working requirements are not met – 7 day working action plan in place
- Two CQC compliance issues identified as having a 'minor' impact. (Support for staff at SMH and Staffing numbers at AH) - addressed
- Lack of Interventional Radiology provision out-of-hours can result in less than ideal patient care – Some out of hours cover is available via adhoc cover where possible from existing radiologists. However where treatment is considered urgent patients will be sent to other sites, such as Oxford.
- Current vacancy levels in all clinical groups increases reliance on temporary staffing potentially having an impact on quality of care - daily, weekly and monthly review of staffing levels on each shift in each area take place in conjunction with review of Nurse staffing and recruitment campaigns including overseas recruitment

- Delays in patient details being updated on Evolve (electronic case note software) represent a clinical risk to patients whose treatment may be delayed as a result - daily monitoring takes place, a process has been put in place for inputting data directly by clinicians or through the administrative team, allied to a risk based approach to the prioritisation of records inputting.

The risk and control framework

The Trust's strategy for managing its risk is to:

- adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's risk management strategy and its related policies, which have all been updated during 2013/14
- manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process
- undertake risk assessments on both existing, new and proposed activities to ensure that:
  - o significant risks are identified
  - o assessments are made of their potential frequency and severity
  - o Risks are avoided where possible, and minimised by implementing durable and effective controls.
  - o Risks are recorded on the Trust's risk register.
- Ensure that the Board reviews the significant risks identified on the Board Assurance Framework and corporate risk register periodically and monitors the delivery of the Trust's objectives.
- Use the risk registers to inform the Trust's business planning and investment decision-making process so that informed decisions are made in the full knowledge of the level of risk.
- record the results of risk assessments on the Trust's risk registers and use them to ensure that any decision to accept risk is taken at an appropriate level in the Trust
- utilise internal and external audit, the healthcare compliance assessment and other assessments by independent regulatory bodies to provide assurance that risk is being managed appropriately
- review the impact of the actions to confirm that they are successfully reducing risk

Within each clinical division there are clinical governance leads and teams attached to the Service Delivery Units, whose role is to ensure that:

- Risks within the division are identified through a process of risk assessment, prioritised, where possible eliminated, and, if not, minimised.
- the importance of managing risk is communicated to all staff within the division
- the Trust Management Committee is made aware of any unacceptable risks that cannot be managed within divisions
- Data from incidents, claims and complaints etc. is reviewed to identify any trends or areas for retrospective action.

Each division also has a clinical audit lead, medical devices lead and control of infection link nurses. Managers are responsible for ensuring effective risk management within their own area.

The Risk Management Strategy also requires liaison with co-employers on broader risks.

The Risk Management Strategy applies to all staff employed by Buckinghamshire Healthcare NHS Trust as well as temporary, agency and contracted staff and stresses the need to involve public stakeholders, as appropriate, in the risk management process.

The Board Assurance Framework (BAF) provides the Trust with a tool for the identification and treatment of principal risks to the achievement of the organisation's objectives. It also provides a structure for the evidence to support (a) the annual governance statement and (b) the statement of compliance with national healthcare regulations.

Documented in the Board Assurance Framework are the levels of unmitigated risk, the controls put in place to minimise principal risks, and the residual risk. The Framework also seeks to give assurances that these controls are effective. Many of these controls are already well established in systems of working which reduce the likelihood of risks being realised.

Where gaps in control or assurance are identified, action plans are developed and put into place to address them. The BAF ensures that appropriate internal and external assurances are in place in relation to the management of all high-risk areas.

The Trust recognises the importance of managing information and personal information in particular, appropriately and securely. The Senior Information Risk Owner (SIRO) is responsible for ensuring the Board has comprehensive and reliable assurance that appropriate controls are in place and that risks are managed in relation to all information used for operational and financial purposes.

The Information Governance and Caldicott committee monitors the performance of the Trust against the requirements of the Information Governance Toolkit. The Trust has self-assessed its performance on information governance using version eleven of the information governance toolkit managed by Connecting for Health. The Trust's overall information governance submission for 2013/14 achieved a score of 76% resulting in a 'satisfactory' rating. During 13/14 Internal Audit Baker Tilly carried out an assessment of the standards in the information governance toolkit and the Trust is waiting for a final report to be issued. The draft report suggests areas to be concentrated on for 2014/15 should be in relation to data mapping and records management and these will be included in the work plan for 2014/15.

REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

This section sets out key sources of assurance to confirm that internal control mechanisms are in place and working effectively. Where weaknesses have been identified these have been addressed with timely and appropriate action.

External reviews

Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England

Buckinghamshire Healthcare NHS Trust was included in this review led by Sir Bruce Keogh due to a higher than expected Hospital Standardised Mortality Ratio over a two year period. The review culminated in an NHS Risk Summit with NHS England in July 2013 and a comprehensive programme of quality improvement commenced entitled 'Every Patient Counts'. The Trust was put into Special Measures with the Trust Development Authority at this time and was provided with the support of an Improvement Director and a buddying

relationship with Salford Royal NHS Foundation Trust. A second risk summit took place in December 2013 where the considerable progress against the required actions was noted.

The Trust now has a new Board approved Quality Improvement Strategy with accompanying Quality Improvement plan.

The Trust was the subject of a Chief Inspector of Hospitals' Inspection between 19-21 and 28 and 29 March 2014 and the results of this inspection are still awaited.

Care Quality Commission (CQC) unannounced visits

The CQC conducted several unannounced visits during 2013/14. These were follow up inspections to unannounced visits in February and March 2013 at both the Stoke Mandeville and Amersham hospitals. The reports, which were published after the end of the financial year, highlighted compliance issues around Supporting Workers and Staffing at Stoke Mandeville Hospital and Staffing at Amersham hospital. At Amersham hospital this was deemed to have a minor impact on people using the service. However at Stoke Mandeville Hospital this was deemed to have a moderate impact on people who use the service and a warning notice was issued. Action plans were put in place to address these issues.

In 2013/14 the first took place in July 2013 at Stoke Mandeville and was followed by a second visit on the following day to Amersham Hospital. A further visit took place in October to Amersham Hospital to follow up actions being taken. The reports raised minor concerns at Stoke Mandeville Hospital concerning staffing levels and "supporting workers". At Amersham Hospital there were concerns around staffing at a moderate concern level and an enforcement notice issued. It was confirmed that an action plan was in place to address the issue to meet compliance by 30th September 2013. The follow up visit to Amersham Hospital in October noted improvements in staffing levels and the enforcement notice was lifted and the impact reduced from moderate to minor

Concerns about the over-use of temporary staff and the impact this has on quality and finance have been discussed by the Board throughout the year. A review of nurse staffing levels was undertaken and an action plan was put in place to strengthen controls with some effect. However risks remain

The CQC found all other essential standards that they reviewed to be compliant, including Care and Welfare of People who use the Services; Safety, Availability and Suitability of Equipment; Cooperating with Other Providers; Respecting and involving people who use services; Safeguarding vulnerable people who use services; Cleanliness and Infection Control; and Assessing and monitoring the quality of service provision.

The CQC launched a new system for Intelligent Monitoring within the year. The Trust showed a marked improvement between the risk rating in the report for October 2013 and the subsequent report for March 2014, in particular :

Overall number of risks reduced from 9 to 5 (Oct 2013 3 Risks, 6 Elevated Risks – March 2014 4 Risks, 1 Elevated Risk)

Risk proportional score from 9.15% to 3.62%

Board Governance Review

During 2013/14 the Board asked KPMG to review the governance structures and processes of the Trust. The final report considered the Trust wide governance arrangements including structure, the Board Assurance Framework (BAF), risk

management strategy and the integrated performance reporting arrangements to provide a balanced assessment of areas where improvements could be made. The key elements of assessment covered:

Board, Board Committee and Divisional Structure - Through a mixture of interviews and review of key documentation they developed an understanding of the existing Board, Board Committee and Divisional governance structure. They considered the structure in line with Monitor's Code of Governance and reviewed key governance documentation including committee terms of reference.

BAF - The BAF was reviewed in line with best practice and guidance from Monitor and the Department of Health. Trust staff were interviewed and papers reviewed papers to understand the Trust's approach in producing and monitoring the document.

Risk Management Strategy – The Trust's approach to risk management was reviewed through consideration of the risk management strategy, risk registers and governance structure, and observation of Risk Monitoring Group, Healthcare Governance Committee (HGC), Trust Management Committee (TMC) and Audit Committee

Integrated Performance Management Reporting - The Trust reporting arrangements were reviewed in the light of industry practice to assess the effectiveness of the performance reporting from a structural and content perspective in place from TMC, through the HGC to the Board.

A number of areas were identified as follows:

Action Needed
Revise Board Committee structure Disband the HGC and implement a NED led Quality Committee providing both an assurance and performance oversightrole to the Board.
Develop Board Committee Structure Implement a second NED led committee providing assurance and a performance role over other key areas to support the Board in delivery of its strategic objectives.
Revisit sub-committee Terms of Reference to minimise overlap of role and to reflect revised structure The roles of each committee should be refreshed via a review of the terms of reference, which in turn should drive the level of detail of reporting to the Board.
Reduce updates to BAF The BAF update frequency should be reduced from a monthly to quarterly.
BAF Summary Sheet Introduce an accompanying single page summary RAG rating each risk identified by either corporate objective or functional area allowing the Board a clear understanding of the overall position and areas to focus upon.
Revise corporate risk register to incorporate gross scores The risk registers only capture the net risk score, the gross risk score is not identified. Therefore the risk registers do not illustrate the effectiveness of the controls in place,
Define the risk appetite and risk escalation procedures. The Trust should formally define its risk appetite and the escalation procedures once a risk is identified.
Reflect KPI headroom in performance reporting The performance reports should be revised to incorporate the level of headroom for each KPI, i.e. how much performance can change by before the RAG rating would change.
Review performance reporting arrangements in respect of reporting lines The reports should reflect the tiers of the Trust's governance structure and provide an

appropriate level of information for the different meetings, for example at TMC level there should be detailed operational performance information; at Quality Committee level the performance information should focused on divisional performance to support tactical decision making; and the information presented to the Board should provide a high level overall summary of performance to facilitate strategic oversight and decision making.
Specify content of divisional reporting An updated format for divisional reporting to the Board Committees and TMC should be agreed to focus on looking forward

An action plan to address each of these developments area was put in place and implemented in 2013/14

Internal Audit

The Internal Audit Programme issued 25 audit reports and six review or advisory reports in 2013/14. The majority of the audit reports resulted in a positive opinion with seven green reports, six green/amber reports and nine amber/ red reports. All red and amber red reports are considered in detail at Audit Committee, with Executive Directors required to present action plans to rectify risk areas identified. Review or advisory reports are not given an assurance rating but are also considered at Audit Committee. There were three red reports issued, which are considered further below.

Data Quality – Data Capture, Validation and Reporting Dementia Screening

Due to the timing of the audit, by the time this was presented to the Audit Committee the Chief Nurse was able to assure the Committee that actions that had been identified internally had been put in place which had increased performance significantly. This metric is now presented as part of the integral performance monitoring scorecard for the Trust.

Access Targets – 18 weeks Referral to Treatment

This has resulted in the development of a comprehensive Action Plan. A similar audit was carried out on Cancer Access targets following a recent issue at another Trust and this audit resulted in a green opinion.

Care Quality Commission – Evidence Gathering, Documentation and Demonstrating Remedial Action taken based on review of evidence

This audit had taken place before the re-inspection by the CQC. A follow up review was immediately commissioned which resulted in significant progress against the recommendations made being identified.'

Compliance with NHS Operating Framework

A comprehensive set of performance reports covering quality, finance, operational performance and workforce have been presented at each Board meeting. These were updated as a result of the KPMG report highlighted above.

The operational performance report demonstrated compliance over the year for all indicators with the following exceptions:

- The 4 hour emergency access target for Q4 which achieved 92.6% against a standard of 95%.

- MRSA, 2 recorded cases (Q3) against a zero standard
- Clostridium Difficile infection rate, 35 recorded cases against a standard of 31
- Admitted patients finishing their pathway – 90% within 18 weeks – the 90% standard was not achieved in Q3 (87.6%) and Q4 (79.2%)

The National Staff Survey for 2013 showed a number of small improvements in some of the key findings over the previous year's results, but overall our results, when weighted and benchmarked, did not change significantly with the exception of two statistically significant improvements; the percentage of staff attending H&S training and the percentage of staff number receiving appraisal in the last 12 months. There were no statistically significant deteriorations. The response rate was 47% of the sampling (a reduction from 52% the previous year).

The staff engagement score dipped to 3.56 against a national average of 3.74, with the Trust being in the bottom 20% when compared to all other Acute Trusts. Going forwards, the Trust will therefore look to improve the staff engagement score.

The Board acknowledged the messages and a comprehensive action plan has been put in place. The Board also tracks staff experience throughout the year, rather than relying on a single snapshot.

A wide range of clinical audits have been undertaken in 2013/14 which are reported in detail in the Quality Account. These provide assurance that controls are in place for clinical processes, and, where risk is identified through these audits this is escalated through the risk management system.

The Trust has declared one Never Event in 2013/14 as follows:

- retained guidewire

This event has been thoroughly investigated and actions have been taken to reduce the risk of recurrence.

The Trust declared no breaches of single sex accommodation during 2013/14.

The organisation has assured itself with regard to the information contained in the Quality Account 2013/14 through the following measures:

- Control mechanisms within the Care Records Service application
- A programme of clinical audit, including engagement with required national audits
- Multiple reviews of the Quality Account whilst in draft by Board members, clinical leads, and contributors to the document to check for accuracy
- Provision of a draft for review by the Buckinghamshire Health and Adult Social Care Select Committee and Health Watch England.
- External audit of compliance with the Quality Account regulations and detailed review of two indicators within the report
- Consideration of the draft Quality Account by the Audit Committee prior to submission to the Board for approval

There have been no Level 3 data security incidents and therefore no information related

incidents have been reported to the Information Commissioner in 2012/13.

2013/14 has continued to demonstrate good progress against the Public Sector Equality duty (PSED).

In October 2012 there was a media exposé of allegations relating to the abuse by Jimmy Savile of vulnerable adults and children, which included references to hospitals where he had a long fund-raising connection during his life. One of the hospitals identified was Stoke Mandeville Hospital. The Secretary State for Health ordered an inquiry into the allegations at Stoke Mandeville Hospital and other NHS hospitals. The final report has been delayed due to fresh allegations received in late 2013.The final report is now due to be published in June 2014. In 2013 the Chair of the Buckinghamshire Safeguarding Children Board conducted a review of safeguarding in the organisation on behalf of both the Safeguarding Children Board and Safeguarding Vulnerable Adults Board. The Safeguarding Boards have confirmed that they are satisfied with safeguarding arrangements and the strengthening culture of safeguarding in the organisation.

Finance

The Trust faced an extremely challenging year financially ending with a £320k surplus compared to its planned surplus of £5m, and within this out-turn the Cost Improvement Plan (CIP) was under delivered by £2.8m . The actual CIP delivery of £21.6m included £3.2m as a result of the Recovery Plan which was initiated mid-year. This delivery included £7m of non-recurrent items, although the full-year effect of schemes rolling into 2014/15 reduced the impact by £1.5m. The main reasons for under delivery against plan were the fact that significant investment was required in response to the Keogh Review and to deliver the resultant Action Plan, additional capacity was required to respond to increased demand both through the urgent care pathway and elective pathways, and some income was lost as a result of contractual challenge . The Trust accessed £5m Revenue PDC in-year to assist with cash management and the servicing of historical debt, in relation to pressures resulting from the under delivery to plan.

The Trust has worked to strengthen its planning and forecasting, and improve its reporting processes. It is enhancing its PMO function and developing new roles to ensure continuous business planning, and total economy strategic alignment. The plan for the 2014/15 financial year is a realistic and deliverable one, and contractually agreed with its commissioners. As a result of the year-end outturn against plan, the issues with delivery of CIPs and pressures on the Trust's cash position the auditor is issuing a qualified vfm conclusion.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Buckinghamshire Healthcare NHS Trust has a generally sound system of governance that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed and that there are no significant internal control issues.

Accountable Officer : Anne Eden
Organisation: Buckinghamshire Healthcare NHS Trust
Signature:
Date:

16. INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

We have audited the financial statements of Buckinghamshire Healthcare NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Trust and Group's Statement of Comprehensive Income, the Trust and Group's Statement of Financial Position, the Trust and Group's Statement of Changes in Taxpayers' Equity, the Trust and Group's Statement of Cash Flows and the related notes 1 to 39. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Buckinghamshire Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditors

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust and Group's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Trust and Group; 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.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Buckinghamshire Healthcare NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended;
- give a true and fair view of the financial position of the Group as at 31 March 2014 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditors

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for a qualified conclusion

In considering the arrangements for securing financial resilience, we concluded that:

- the Trust did not deliver on its operating plan for 2013/14 and was reliant on one-off non recurring items to achieve a small surplus;
- the Trust required temporary financial support from the Department of Health to manage its cash position; and
- the processes for ensuring that the schemes underpinning the 2013/14 cost improvement programme were insufficiently robust to ensure the individual schemes and therefore the overall required cost reduction was deliverable. As a result, the Trust did not deliver its required cost improvements and consequently relied upon a significant proportion of non-recurrent savings not included in the original programme.

The Trust has implemented a revised process for developing its future cost improvement plans. It has also reviewed its governance arrangements and implemented a revised governance structure to support robust financial challenge and transparency around the financial position.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in November 2012, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Buckinghamshire Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Maria Grindley
for and on behalf of Ernst & Young LLP
Reading
5 June 2014

17. Appendices

17.1.Appendix 1 - Become a member of the Trust

As part of our aim to become an NHS Foundation Trust, we would like to invite you to become a member of the Trust. To become a member you can join on our website www.buckshealthcare.nhs.uk or request information from us at:

Membership office

Buckinghamshire Healthcare NHS Trust

Amersham Hospital

Whielden Street

Amersham

Bucks

HP7 0JD

17.2. Appendix 2 - Feedback on the annual report 2013/14

It is important our annual report is easy to read and understand, and it is available in a variety of versions, including in other languages and as an audio book, on request. In producing ours we have used guidance on content from the Department of Health, as well as learning from reports produced by other NHS trusts.

We value feedback on this year's report – please complete the feedback form below and post the page to the address shown. Alternatively, you may email your comments to communications@buckshealthcare.nhs.uk.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information in this annual report was easy to understand					
There was enough information about the Trust and its services					
There was enough information about the Trust's achievements					
There was enough information about the Trust's finances					
The layout of the document was clear					

Please post feedback to:

Communications

Buckinghamshire Healthcare NHS Trust

Amersham Hospital

Whielden Street

Amersham

Bucks HP7 0JD

Or telephone: 01494 734959

Or email: communications@buckshealthcare.nhs.uk

17.3.Appendix 3 - Glossary

Acute hospital services Medical and surgical interventions provided in hospitals.
Accruals An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.
Agenda for Change Agenda for Change is the pay system for the majority of NHS staff.
Annual governance statement The chief executive as the accounting officer is required to make an annual statement alongside the accounts of the Trust, which provides a high-level summary of the ways in which risks are identified and the control systems in place.
Annual health check The annual health check produced by the Care Quality Commission involves the assessment and rating of the performance of each NHS organisation. The annual health check rating for the previous financial year is published in October.
Assets In general, assets include land, buildings, equipment, cash and other property.
Assurance framework (and Board Assurance Framework) The assurance framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the statement on internal control.
Audit commission They are an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. They appoint the external auditors.
Better payment practice code The better payment practice code requires the Trust to aim to pay all valid non-NHS

invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Break-even (duty)

A financial target. In its simplest form it requires the Trust to match income and expenditure.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if its costs exceed £5000 and its useful life expectancy is greater than one year.

Care pathway

This is the route and interactions with healthcare services that a patient will take from their initial meeting with a GP to completion of their treatment.

Care Quality Commission(CQC)

The Care Quality Commission provides an independent assessment of the standards of healthcare services, whether provided by the NHS, the private sector or voluntary organisations. The CQC replaces the Healthcare Commission.

Charitable funds

Our charity, registered number 1053113 includes a general amenity fund (unrestricted), a research fund (restricted) and an endowment fund.

Choose and book

It is the government's aim to allow patients to choose the hospital they are treated in. Patients needing elective treatment are offered a choice of four or five hospitals once their GP has decided that a referral is required. These could be NHS trusts, Foundation Trusts, treatment centres, private hospitals or practitioners with a special interest operating within primary care. Choose and book is a national service that, for the first time, combines electronic booking and a choice of place, date and time for first outpatient appointments.

Clinical Commissioning Groups

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the GPs in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.

Clinical division

The Trust's organisation management structure is based on three clinical divisions, each led by a divisional clinical chair who is a medical consultant supported by an associate chief nurse and associate chief operating officer. The three divisions are:-

- integrated medicine
- surgery and critical care
- specialist services.

Clostridium difficile (C. difficile)

Clostridium difficile is a bacterium that can cause an infection of the gut and is the major infectious cause of diarrhoea that is acquired in hospitals in the UK.

Commissioning

A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.

Community care

Healthcare care provided in a community setting such as at home or from a community hospital.

CQUIN (Commissioning for Quality and Innovation) payment targets

These new payment targets are aimed at driving up quality in certain areas. They have been developed to support implementation of *High Quality Care for All*.

Cost improvement programme

The 'savings' plan agreed for 2009/10.

Corporate trustee

A corporate trustee is a corporation which has been appointed to act as a trustee of a charity. In the case of the NHS, the NHS Trust Board is the corporate trustee of our charitable funds.

Current assets

Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next twelve months.

Disability equality scheme

The Disability Discrimination Act amended in 2005 gives the Trust 'general' and 'specific' duties to promote disability equality.

Eighteen week and cancer waits

The NHS improvement plan gave a commitment that by December 2008 no one will have to wait longer than 18 weeks from GP referral to hospital treatment. However, many patients will be seen much more quickly. For example by December 2005, cancer patients were guaranteed a maximum two month wait from urgent GP referral to first treatment and a maximum one month wait from diagnosis to first treatment for all cancers.

Elective inpatient activity

Elective activity is where the decision to admit to hospital could be separated in time from the actual admission, i.e. planned. This covers waiting list, booked and planned admissions.

Emergency inpatient activity

Emergency activity is where admission is unpredictable and at short notice because of clinical need.

Equality delivery system (EDS)

The EDS was designed in 2011 as a tool to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is about making positive differences to healthy living and working lives.

Evolve

Evolve, is a new electronic document and records management system (EDRM) which has been rolled out from Autumn 2013.

Executive directors

The executive directors are senior employees of the NHS Trust who sit on the Board of Directors and will include the chief executive and finance director. Executive directors have decision-making powers and a defined set of responsibilities thus playing a key role in the day to day running of the organisation.

Francis report

The Francis Report 2013 is the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry by Robert Francis QC. It was published on Wednesday 6 February 2013 and makes recommendations to the Secretary of State based on the lessons learnt from Mid Staffordshire. http://www.midstaffspublicinquiry.com/

GDP

Gross domestic product – a measure of the value of national economic activity.

Governance

Governance arrangements are the 'rules' that govern the internal conduct of an organisation by defining the roles and responsibilities of key officers/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements.

Health and Social Care Act 2012

The Health and Social Care Act 2012 is an Act of the Parliament of the UK. It is the most extensive reorganisation of the structure of the NHS in England. It abolished NHS primary care trusts and strategic health authorities from April 2013, with clinical commissioning groups made up of GPs now responsible for buying health services for their population.

Health Education Thames Valley

Health Education Thames Valley is the local education and training board covering Buckinghamshire and responsible for NHS workforce planning, education and training in the area. It is a committee of Health Education England, the organisation established as part of the Health and Social Care Act 2012 to lead on workforce issues nationally.

HSMR

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality used by the NHS that measures whether the death rate at a hospital is higher or lower than you would expect.

ICT

Information and communications technology.

Integrated business plan

The Trust's Integrated Business Plan (IBP) describes services provided by Buckinghamshire Healthcare. It outlines plans for the Trust to operate as a legally-constituted, financially viable and well- governed NHS Foundation Trust over a five-year period and will form part of our Foundation Trust application to the Trust

Development Authority.
Integrated care Integrated care – also known as *coordinated care*, *comprehensive care*, *seamless care* – is a worldwide trend in health care reforms and new organisational arrangements that focuses on more coordinated services across acute, community and primary care sectors.
International Financial Reporting Standards (IFRS) IFRS are the standards, interpretations and the framework adopted by the International Accounting Standards Board (IASB) to promote high quality financial standards globally.
Key performance indicators (KPIs) KPIs are the nationally recognised method for calculating performance in NHS acute trusts and are defined by the NHS Information Authority. In 2009/10 the KPIs covered existing commitments and national targets set out by the Department of Health (DH) and Care Quality Commission (CQC); clinical quality, outcome and clinical efficiency indicators and activity levels, workforce and health & safety indicators.
Local health economy The NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.
MARS Mutually agreed resignation scheme.
Methicillin resistant staphylococcus aureus (MSRA) This is a strain of a common bacterium which is resistant to an antibiotic called methicillin.
NHS Buckinghamshire The local primary care trust and commissioner of NHS services for Buckinghamshire people until April 2013. Now replaced by clinical commissioning groups.
NHS foundation trust(FT) NHS foundation trusts have been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people.
NHS South of England NHS South of England officially came into effect in October 2011, clustering former

strategic health authorities – NHS South Central, NHS South East Coast and NHS South West. Strategic health authorities were succeeded in April 2013 by a new NHS Commissioning Board, as part of the Health and Social Care Act 2012.

NHS trusts

NHS Trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as commissioned by PCTs.

Non-executive directors

Non-executive directors, including the chairman, are Trust Board members but they are not full time NHS employees. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the executive directors to account for organisational performance.

Order communications

An electronic system for the requesting and reviewing of test results. For example, pathology results.

Outpatient attendance

An outpatient attendance is when a patient visits a consultant or other medical outpatient clinic. The attendance can be a ‘first’ or ‘follow up’.

Overview and scrutiny committees (OSC)

OSCs have the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants.

Patient administration system (PAS)

A computer system used to record information about the care provided to service users. The data can only be accessed by authorised users.

Patient Advice and Liaison Service (PALS)

All NHS trusts are required to have a Patient Advice and Liaison Service. The service

offers patients information, advice, quick solution of problems or access to the complaints procedure. PALS are designed to offer on the spot help and information, practical advice and support for patients and carers.

Payment by results (PbR)

Payment by results (PbR) aims to be a fair and transparent, rules-based system for paying NHS Trusts. It uses a national price list (tariff) linked to activity and adjusted for case complexity.

Private finance initiative (PFI)

The private finance initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects

Primary care

Family health services provided by family doctors, dentists, pharmacists, optometrists, and ophthalmic medical practitioners.

Protected characteristics

The Equality Act 2010 makes it unlawful to discriminate against people with a 'protected characteristic' (previously known as equality strands / grounds). The protected characteristics are Age, Disability, Gender Reassignment, Pregnancy and Maternity, Marriage and Civil Partnership, Race, Religion or belief, Sex and Sexual Orientation.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required. Provisions are included in the accounts to comply with the accounting principle of prudence.

Public Sector Equality Duty (PSED)

The Equality and Human Rights Commission published new guidance in January 2013 on the public sector equality duty (PSED) under the Equality Act, to help public authorities encourage good relations, promote equality and eliminate discrimination in

the workplace and in delivering public services.
Quality account From 2009/10 onwards all NHS trusts have to publish quality accounts to give information about the quality of the services being delivered.
Revenue Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.
Ring-fenced Funding specifically designated for a purpose and which can only be used for that purpose.
RiO An electronic patient records system for community health organisations.
Risk register A register of all the risks identified by the organisation, each of which is assessed to determine the likelihood of the risk occurring and the impact on the organisation if it does occur.
Scannappeal An independent registered charity that's objective is to raise money for scanners and other life saving medical equipment for hospitals in Buckinghamshire.
Secondary care Care provided in hospitals.
Service standards The Trust's service standards focus on themes around communication, courtesy, compassion and commentary. For the first time they set out the standards of behaviour we expect all of our staff to deliver, with every interaction, every day, with

every patient or colleague.

Tariff / national tariff

The national tariff underpins the implementation of the payment by results policy by providing a national price schedule for commissioning services for patients in England. The tariff is a schedule of prices for healthcare resource groups (HRGs). These HRG's cover a range of clinical procedures, treatments and diagnoses that cover a large proportion of hospital services in England.

Tripartite agreement

This is an agreement between three parties.

Trust Board

The Trust Board comprises the chairman, executive and non-executive directors and is the body responsible for the operational management and conduct of a particular NHS Trust.

Trust Development Authority

The NHS Trust Development Authority (NHS TDA) is a national body established through the Health and Social Care Act 2012 to support the performance management of NHS trusts and manage foundation trust applications. It has special health authority status and also looks at clinical quality, governance and risk in NHS trusts and oversees the non-executive appointments of chairs, non-executive directors and trustees for NHS charities.

Whole system reform

In relation to our agenda this involves looking at the whole system of NHS care in Buckinghamshire, for example the organisations and professions involved, and improving it collaboratively.

Working capital

Working capital is the current assets and liabilities (debtors, stock, cash and creditors) required to facilitate the operation of an organisation.

17.4 Appendix 4 – Sustainability report

Sustainability has become increasingly important as the impact of people's lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities, staff and the environment by working hard to minimise our carbon footprint.

The NHS's aim is to reduce its carbon footprint by 10% between 2009 and 2015. By reducing the amount of energy used in our buildings we can contribute to this national objective We acknowledge that there is also a financial benefit in reducing the Trust's energy bill.

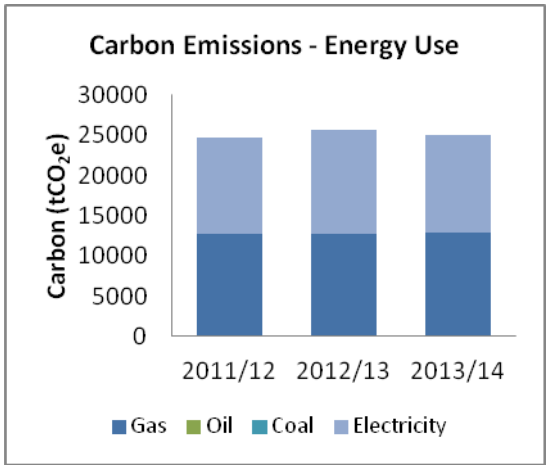
Our energy costs increased by 8.4% between 2012/13 and 2013/14. However, our total energy consumption has fallen in the year from 88.68 to 87.32 MWh, which is a reduction of 1.6%.

-2.4%

Our carbon emissions have fallen in the year from 25.599tCO_2e to 24.997tCO_2e, which is a reduction of 2.4%.

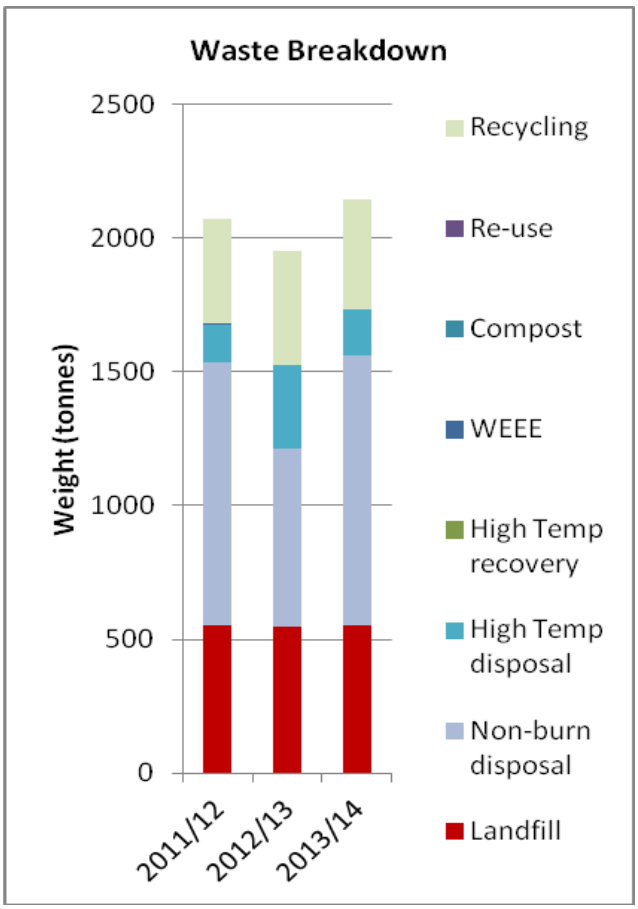
Renewable energy represents 0% of our energy usage, but we generate 0.1% of our own energy on site.

Our relative energy consumption has changed during the year from 0.63 to 0.62 MWh per m^2.



Our water consumption has reduced by 790m^3 between 2012/13 and 2013/14. This is the seventh consecutive year that we have reduced our water consumption. In 2012/13 we spent £292,294 on water and sewerage compared with £331,794 in 2013/14.

Climate change brings new challenges to the Trust both in its effect on the estate and on patient and staff welfare. The Trust's objectives and strategy ensure that the delivery of the organisation's activities and infrastructure are prepared for climate change and adverse weather events. The Trust has a statutory duty to assess the threats posed by climate change and in this way Property Services manage their own risk register. This quantifies and prioritises risk in order to manage and adapt our estate.



In terms of our waste, we produced a total of 1,952 tonnes in 2012/13 against 2,143 in 2013/14. Our recycling percentage decreased from 0.0046% to 0.0040% between the years 2012/13 and 2013/14. Out total waste tCO_2e increased in the period from 162.98 tCO_2e in 2012/13 to 167.88 tCO_2e in 2013/14.

In addition to our focus on carbon emission reduction we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out in the Trust policies on sustainable procurement and is delivered within our suppliers' contracts.

Our organisation will be updating its current Sustainable Management Development Plan during 2014/15 for consideration by the Board. As an organisation that acknowledges its responsibility towards creating a sustainable future, the Trust runs awareness campaigns that promote the benefits of sustainability to our staff.

The Board lead for sustainability is Clinton Green, Director of Property Services, who ensures that sustainability issues have visibility at the highest level of the Trust.

A sustainable NHS can only be delivered through the efforts of its Board and all of its staff. We are working with Human Resources to include carbon reduction within all staff job descriptions. The awareness campaigns have proven that cost savings and associated reductions in carbon emissions can be achieved.

The NHS places a substantial burden on the transport infrastructure and, as well as having a green travel plan for staff, we contract with Arriva buses to provide more than 100,000 patient and staff journeys each year to our major hospital sites. We also jointly sponsor the Bucks Community Transport Hub which assists with individual patient travel arrangements to our community hospitals and GP centres. We are continually researching additional opportunities to reduce and change travel patterns across the Buckinghamshire county region.